Inter-Rater Reliability Analysis of Data to Document the Consultative Examination Process

Volume 2: Appendices

November 4, 2012

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APPENDIX A:

SUMMARY OF RESEARCH QUESTIONS, MEDICAL CONSULTANT INSTRUMENT, AND EXAMINER INSTRUMENTS

Appendix Exhibit A.1. Cross Walk of SSA Research Question with Data Elements from Medical Consultant and Examiner Questions

SSA Research Questions	*Sections/Questions*
1. Was the CE requested according to SSA regulations?	Sections C, D, F, N, O, and Q; Questions M1 and 2
2. Why was the CE requested, e.g., additional evidence was needed, medical evidence could not be obtained from the treating source, highly technical or specialized medical evidence was not available from the treating source, to resolve conflicts or inconsistencies in the file, or	Question C2[1]
Was there an indication of a change in the applicant's condition that was likely to affect his/her ability to work?	Question N9
Were guidelines regarding development of all applicable sources and the necessary follow-ups with these sources followed?	Sections C, D, and Q
Was the CE needed to adjudicate the case?	Question C2
Was there a follow-up contact with the CE provider to obtain additional information; what additional information was requested; and in the opinion of the reviewer, did this additional information increase the quality of the CE report?	Section Q
Does the CE provider list the findings or say "see attached report?"	Question G2
3. Was the CE purchased from a qualified medical source, per 404.1519(g)?	Section F
Was there evidence the medical source was board certified?	Question F3[2]
Was the CE area of specialty consistent with the type of impairment being evaluated?	Section B. and Questions F.1.-3
4. What medical evidence of record (MER) and/or other background was sent to the CE provider?	Section G
5. For hearing office cases, was one or more CE requested at an earlier adjudicative level in the claims process?	Questions N14
If so, why did the hearing office request a CE?	Questions N15 and N16
What was the quality of the hearing office CE report?	Questions P2 and P3
What was the quality of the earlier CE report?	Question N.17
Is there a difference in CE quality or the need for a CE in single decision maker cases versus traditional cases?	Questions P2 and P3
If the prior CE was recent (within 6 months), why did the judge not use it and order a new examination?	Questions N16 and N17

[1] This question was simplified to whether there was a rationale for ordering a CE on the worksheet after the review teams encountered major reliability problems in trying to assess the specific reasons in the research question noted in question 2

[2] The COMS management team used the information on the CE provider to look up whether the CE was reviewed by a board certified clinician.

SSA Research Questions	***Sections/Questions***
6. To what extent is the chief complaint and detailed descriptions of the history of the chief complaint reflected in the reported history?	Questions I3a-I6
7. Is the chief complaint addressed in the examination?	Question I3
Were any other abnormalities alleged in the history or found in the examination?	I1L, K2m, k2n, K2t, K3c, K4b, and M5
Were these addressed in the report? (Note: The chief complaint refers to the primary alleged disabling impairment. If the CE was requested for a different impairment, both should be considered and addressed.)	Questions I3a-3d
8. To what extent is there a description and disposition of pertinent positive and negative detailed findings based on the history, examination and laboratory tests related to the major complaint(s)?	Sections I, K., L, and M
9. To what extent are laboratory and other tests performed according to the requirements stated in the Listings of Impairments?	Section M
Were the laboratory and other tests requested by the DDS or ALJ appropriate and necessary to adjudicate the case?	Question M4
Was the physical examination performed according to the requirements stated in the Listings of Impairments?	Section K
10. To what extent is the diagnosis and prognosis described in each report?	Questions N1-N8
To what extent did the CE address symptoms?	
11. Did the CE authorization request a medical source statement?	Section H
To what extent does the CE report include an opinion from the medical source about the applicant's ability, despite his/her impairment(s), to do work-related activities, such as pushing/pulling/reaching, sitting, standing, walking, lifting, carrying, handling objects, hearing, seeing, speaking, and traveling (available in hearing office cases only); and,	Section O
In cases of mental impairment(s), the opinion of the medical source about his/her judgment, ability to deal with change, ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers and work pressures in a work setting?	Section L
12. For pediatric examinations, to what extent does the CE report describe the opinion of the medical source about the child's functional limitations compared to children his/her age who do not have impairments in acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, caring for him/herself, and health and physical well-being?	Questions O4a-O4f
Was the CE report personally reviewed and signed by the medical source who actually performed the examination?	Question P1
13. To what extent does CE quality vary by impairment type, claim type, regulation basis code, specialty area, etc.?	Administrative data (Section A), Questions P2 and P3
14. Identify any difference in overall quality rating and specify all differences found between a CE purchased at the request of hearing office (ODAR) or initial level (DDS).	(Section A), Questions P2 and P3
15. In what time frames are CE examination reports received?	Section E
What was the time frame from the date the CE was requested by the disability examiner to the date the CE actually was scheduled?	Questions E1 and E2
Is there a correlation between timeliness and quality?	Section E, Questions P2 and P3
Is there a relationship between the fee paid for a CE and the quality of the CE report received?	Question D6, P2, and P3

Appendix Exhibit A.2. Examiner Questions

	A. Examiner Review and Administrative Data (loaded using SSA administrative data)	
All	1. Rater Number (enter)	Assigned by Design Team
All	2. SSA Assigned Case folder Number (enter)	Administrative data
All	3. Claim type (DI, DIB, DC, etc.) (from SSA data)	Administrative data
All	4. Claim decision (Regulation Basis Code) (from SSA data)	Administrative data
All	5. Level of administrative decision (from SSA)	Administrative data (1=initial level, 2=hearings level)
All	6. State of decision	Administrative data
All	7. Date of decision	Administrative data
	B. Type of Exam	
(All)	Enter File Count	__ (note: must be a number)
(All)	1. Type of Exam	1. Adult physical 2. Adult mental 3. Child physical 4. Child mental
If B1=1	2. For adult physical only, what medical specialty type of exam was received by SSA?	1. General Medicine or Internal Medicine or Family Medicine 2. Cardiology 3. Neurology 3a. Speech Lang. Path. 4. Pulmonary 5. Rheumatology 6. GI 7. Orthopedic or Musculoskeletal 8. Neurosurgery 9. PM & R 10. Ophthalmology 11. ENT 11a. Audiology 12. Hematology/Oncology 13. Endocrinology 14. Genitourinary 15. Skin Diseases 16. Other: _____
If B1=2	3. For adult mental health CE's only, what type of exam was received by SSA?	1. Mental Status examination by Interview 2. Psychological (and Intelligence) Testing 3. Both 1 and 2

If B1=3	4. For child physical CE's only, what medical specialty type of exam was received by SSA?	1. General Pediatrics or Family Medicine/Growth/Multiple Body Systems/Immune System 2. P. Cardiology 3. P. Neurology 3a. Speech Lang. Path. 4. P. Pulmonary 5. P. Rheumatology 6. P. GI 7. Orthopedic or Musculoskeletal 8. Neurosurgery 9. PM & R 10. Ophthalmology 11. ENT 11a. Audiology 12. P. Hematology/Oncology 13. P. Endocrinology 14. Genitourinary 15. Skin Diseases 16. Other: _____
If B1=4	5. For child mental health CE's only, what type of exam was received by SSA?	1. Mental Status examination by Interview 2. Psychological (and Intelligence) Testing 3. Both 1 and 2
All	6. List (up to) the **first three** diagnoses and/or impairments listed by the CE provider at the end of the CE Report. ***Only list diagnoses within the purview of the type (medical specialty) of CE reviewed.***	1. _____ 2. _____ 3. _____
	D. Process of ordering a CE	
If A5=1	1. How many Medical Sources (MS's) were identified on the 3368 or 3820?	LIST NUMBER: __
	2. How many MS's provided medical information (MER)? (There may be more (or less) in the E-file than are listed on the 3368/3820.)	LIST NUMBER: __
If A5=1	3. Number of MS's providing medical information before initiating the CE purchase?	LIST NUMBER: __
If A5=1	4. How long did the disability examiner wait [after the last request for MER] before purchasing the CE?	1. Less than 21 days/ 2. 21days- 1 month/ 3. More than1 month 4. Cannot determine
If A5=1	5. Did a DDS medical consultant either request the CE or agree with the examiner's decision to order a CE?	1. Yes 2. No 3. Unknown

All	6. What was the cost of the basic (clinical "hands-on") CE? (For mental health CE's that include cognitive testing, include the cost(s) of the tests) **NOTE: enter "0" if cost data are not available**	Amount: $____.
	E. Claim Dates: DDS for Initial Level decisions; ALJ for Hearing Level decisions	
All	1. What was the date the CE was requested by the Disability Examiner?	1. Mn/dd/yy: 2. Unknown
All	2. What was date the CE was scheduled?	1. Mn/dd/yy: 2. Unknown
All	3. What was the date CE Report was received by the DDS or ALJ?	1. Mn/dd/yy: 2. Unknown
	F. Qualifications of the CE Provider	
All	1. What was the licensure (profession) of the CE provider?	1. Licensed physician 2. Licensed Psychologist (PhD or PsyD.) 3. Masters Degree or less (e.g., Masters or Bachelors degreed Social Worker) 4. DED/EDD 5. Other
All	2. Was the CE provider's license status noted (must show expiration date) in CE Report)?	1. Yes 2. No
All	3. What was the CE provider's name? (MD's/DO's only)?	1. _____ _____ _____ 2. CE provider not a MD or DO
All	4. In what State was the CE performed?	__ __
All	5. Was the CE provider a treating source?	1. Yes 2. No
If F5=No	6. Was a treating source asked to perform the CE?	1. Yes 2. No 3. Unknown
	H. Medical Source Statement from CE Provider	
All	1. Did the DDS Worksheet or ALJ's opinion note that an MSS was expected or requested?	1. Yes 2. No
All	2. Did the CE authorization or Invoice request an MSS?	1. Yes 2. No (includes not finding a CE authorization or Invoice request)

	Q. Follow- up Contact with CE Provider	
All	1. Was there any follow-up contact with the CE Provider?	1. Yes 2. No 3. Unknown
If Q1=yes	2. Was it to obtain additional, i.e., omitted information?	1. Yes 2. No
If Q1=yes	3. Was it to clarify or correct a finding or statement in the CE Report?	1. Yes 2. No
If Q1=yes	4. Was it to obtain a signature?	1. Yes 2. No

Appendix Exhibit A.3. Medical Consultant Questions

	C. Worksheet Review	
All	1. Was a DDS Worksheet for **THE DECISION LEVEL OF *YOUR* CE** (INITIAL OR ALJ) in the E-file?	1. Yes 2. No (Go Section G)
If C1=1	2. Was ***any*** reason given on ***your*** Worksheet for ordering ***your*** CE?	1. Yes 2. No (Go to Section G)
If C2=1	3. Did the Worksheet note that the CE was ordered to obtain more recent evidence?	1. Yes 2. No
	G. Medical Evidence Documentation	
All	1. Did the CE provider refer to or mention Medical Records as a group or the specific names of individual items of medical records ***in any way*** in the CE Report?	1. Yes (**EXCLUDES** CE Reports in which there was a comment that there was no MER to review. 2. Yes (**INCLUDES** *only* those CE Reports in which there was a comment that there was no MER to review (Go to Section I)) 3. No (Go to Section I)
If G1=1	2. Did the CE provider list ***deliberately*** at least one specific item of MER he/she reviewed in the CE Report?	1. Yes (Go to Section I) 2. No (GO to Section I)
	I. Medical History- Present Illness (HPI)	
	GENERAL INSTRUCTIONS: **For the following items related to the Medical History, specific guidance is provided in the Codebook for locating the needed information and how to approach coding the MPR Website Template.**	
All	1. Did the CE provider ***specifically*** **indicate in a separate comment** who gave the medical history?	1. Yes-Claimant only 2. Yes-Claimant and another person (e.g., parent) 3. Yes-Other person(s) only 4. No
All	2. Was there a ***specific comment*** in the CE Report about the reliability of the medical history?	1. Yes 2. No
All	3. Per Study definition (***SEE CODEBOOK for definition***), was there a Chief Complaint?	1. Yes 2. No (Go to I4)
If I3=1	3a. Was the Chief Complaint clarified (differential diagnosis explored or a diagnosis confirmed)?	1. Yes 2. No

If I3=1	3b. Was ***any*** information provided that reflected on the severity of the Chief Complaint-related medical condition? **Note:** Consider information about functional consequences, including ADL's, as clarifying severity.	1. Yes 2. No.
If I3=1	3c. Was the approximate time of onset of the Chief Complaint-related medical condition described (**SEE CODEBOOK for required details regarding estimating an onset "date"**)?	1. Yes 2. No 3. Birth or before
If I3=1	3d. Was anything that made the Chief Complaint-related medical condition better (including treatment) or worse described? **Note: This question is *NOT* asking about what initially caused or led to the development of the Chief Complaint-related diagnosis, *or* what its initial Rx was.**	1. Yes 2. No
All	The following I4 questions are based on any **OTHER** allegation(s) or complaint(s) that are **NOT** due to the Chief Complaint-related medical condition.	
All	4. Were there any allegations or complaints possibly related to any medical condition, diagnosis, impairment, or process that was **not** related to the Chief Complaint, as you have defined it for this Study (**SEE CODEBOOK FOR ADDITIONAL CLARIFICATION**)?	1. Yes 2. No (Go to I5)
If I4=1	4a. Was at least one other allegation **not** related to the Chief Complaint (CC)-related medical condition clarified (differential diagnosis explored or a diagnosis confirmed)?	1. Yes 2. No
If I4=1	4b. Was ***any*** information provided that reflected on the severity of at least one "non CC" allegation or possible impairment? **Note:** Consider information about functional consequences, including ADL's, as clarifying severity.	1. Yes 2. No
If I4=1	4c. Was the approximate time of onset of at least one "non CC" allegation or possible impairment described (**SEE CODEBOOK for required details regarding estimating an onset date**)?	1. Yes 2. No 3. Birth or before
If I4=1	4d. Was anything that made any "non CC' allegation or possible impairment better (including treatment) or worse described? **Note: This question is *NOT* asking about what initially caused or led to the development of the "non CC"- related diagnosis, *or* what its initial Rx was.**	1. Yes 2. No

All	5. Was there a history of inpatient and outpatient diagnostic/treatment experiences related either to the Chief Complaint-related medical condition or to a "non CC" allegation or possible impairment?	1. Yes 2. No
All	6. Was at least part of the Medical History described in narrative format (i.e., was the Medical History **not** solely a checklist)?	1. Yes 2. No
	J. Additional Medical History	
	GENERAL INSTRUCTIONS: Be alert for the following items either to be in a separate section of the Medical History after the History of Present Illness or included within the History of Present Illness, or somehow otherwise combined with other items.	
If B1=1 or B1=3	1. Was a Review of Systems documented?	1. Yes 2. No
All	**2**. Were any medications listed **anywhere** in the CE Report?	1. Yes 2. It was noted that no medication was being taken (GO TO J3) 3. No (GO TO J3)
If J2=1	2a. Was at least one dose regimen noted? **Note:** A dose regimen = dose **+ dose schedule** (e.g., " 50 mg. **BID**")	1. Yes 2. No
All	3. Did the CE provider inquire about a history of use of alcohol and/or illicit substances?	1. Yes, for **both** alcohol **and** illicit drugs 2. Yes, for alcohol **only** 3. Yes, for illicit drugs **only** 4. No
All	4. Was the past medical history (PMH) noted?	1. Yes 2. No
If B1=3 or B1=4	5. Was the pre-kindergarten growth and development history noted?	1. Yes 2. No 3. reached kindergarten age
All	6. Was the work/school history noted?	1. Yes 2. No 3. Pre-kindergarten age

If B1=1	7a. Was the family medical history (FMH) noted?	1. Yes 2. No
If B1=2, 3, **or** 4	7b. Was the family medical history (FMH) pertinent to the claimant's allegations noted?	1. Yes 2. No
All	8. Was ***any*** part of the Medical History recorded on a standardized form?	1. Yes 2. No
	If B1 = 2 OR B1 = 4, GO to Section L (MENTAL HEALTH)	
	If B2 = 10 OR B4 = 10 GO to Section K5 (OPHTHALMOLOGY)	
	If B2 or B4 = 11 or 11a GO to Section K6 (ENT)	
	K. Physical Exam Findings	
	GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for a cardiac allegation, "sensation" does not need to be described with the same amount of detail as when the claimant alleges peripheral neuropathy. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual functional capacities for work are. **Note: SOME OF THE DETAILS RELATED TO SECTION K MIGHT BE LOCATED ON A SEPARATE STANDARDIZED FORM WITHIN THE CE REPORT. ALWAYS LOOK FOR SUCH AN EXTRA REPORT, ESPECIALLY FOR MUSCULOSKELETAL AND NEUROLOGICAL PHYSICAL FINDINGS AND FOR INFO ABOUT ASSISTIVE DEVICE USE.**	
	1. ALL PHYSICAL EXAMS (*EXCEPT* Ophth. and ENT):	
If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1a. Was there a **specific comment** that the claimant's identification was verified at the CE?	1. Yes 2. No

If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1b. Was pulse rate, blood pressure, and/or respiratory rate recorded?	1. Yes - at least 2 of 3 items were recorded 2. Yes – only 1 item was recorded 3. No
If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1c. Was station **or** gait described?	1. Yes 2. No
If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1d. Was use of an assistive device referred to in the CE Report?	1. Yes – Claimant uses an assistive device ***AND*** technique of use was described ***AND*** it is reasonable to infer that the CE provider directly observed its use. 2. Yes – Claimant alleges use of an assistive device ***BUT*** either the technique of use was not described, or, if it was, it was not clear, i.e., reasonable to infer, that the CE provider personally observed its use). 3. Yes – it was noted that the claimant did not use an assistive device. 4. No
If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1e. Was the ability to dress/undress or other gross/fine hand functions described?	1. Yes 2. No
If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1f. Was Weight **and** Height (Length, in lieu of height, < 2 yrs.) noted?	1. Yes for (Wt. **and** Ht.) – or (Wt. **and** Length) 2. No for Wt. alone **or** Ht. alone (**or** Length alone) **or** none of these.
If B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠11a	1g. Was Head circumference noted?	1. Yes 2. No
If B1=3 AND B2 ≠ 10 and B2 ≠ 11 and B2 ≠11a	1h. General appearance?	1. Yes 2. No
If B1=3 AND B2 ≠ 10 and B2 ≠ 11 and B2 ≠11a	1i. Obvious vision problem?	1. Yes 2. No

If B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠11a	1j. Obvious hearing problem?	1. Yes 2. No
If B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠11a	1k. Facial dysmorphism?	1. Yes 2. No
If B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠11a	1l. Skeletal abnormalities?	1. Yes 2. No
If B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠11a	1m. Other congenital anomaly?	1. Yes 2. No
If B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠11a	1n. Nutritional status?	1. Yes 2. No
If B1=1 or B1=3 AND B2 ≠ 10 and B2 ≠ 11and B2 ≠ 11a AND B4 ≠ 10 and B4 ≠ 11and B4 ≠11a	1o. Was ***any*** part of the physical exam recorded on a standardized form?	1. Yes 2. No
	2. Generalist Exams **Did the CE Report adequately address:** **GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for a cardiac allegation, "sensation" does not need to be described with the same amount of detail as when the claimant alleges peripheral neuropathy. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual functional capacities for work are.**	
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2a. Was there a comment about overall claimant distress?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2b. Head, eyes, ears, nose, oral cavity?	1. Yes - at least 2 of 5 items were addressed 2. Yes – only 1 item was addressed 3. Yes – but there was only mention of the HEENT group of findings, and individual findings were not referred to or described 4. No

If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2c. Lung auscultation?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2d. Cardiac rhythm?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2e. Cardiac auscultation (heart sounds, murmur, **and/or** gallop)?	1. Yes – at least 2 of 3 items were described. 2. Yes – only 1 item was described. 3. Yes – but there was only mention of the cardiac group of findings, and individual findings were not referred to or described 4. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2f. Abdomen: 1-liver size or spleen size or "organomegaly;" 2-bowel sounds (or bowel "benign"); 3-ascites; 4-tenderness; 5-masses)?	1. Yes – at least 3 of these 5 items were described. 2. Yes – only 1 or 2 of these 5 items were described. 3. Yes – but there was only mention of the abdominal group of findings, and individual findings were not referred to or described 4. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2g. Peripheral pulses (wrist or feet) **or** carotid strength?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2h. Peripheral edema?	1. Yes 2. No
If B4 =1,2,4,5,6,12,13,14,15,16	2i. Perspiration **or** crying?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2j. Re Joints (including spine) and any myofascial findings?	
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	(1). effusion **or** swelling?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	(2). Tenderness (includes "**points**")?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	(3). heat **or** redness?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	(4). synovial thickening?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	(5). ROM (including spine) in degrees (**degrees not necessary for "Yes" if ROM normal**)?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2k. Muscle bulk **or** atrophy?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2l. Muscle spasm **or** tone (includes any comment noting spasticity, flaccidity, rigidity, softness, and/or firmness)?	1. Yes 2. No

If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2m. SLR/tension signs **in degrees (degrees not necessary for No. 2.)**?	1. Yes (SLR was abnormal) 2. Yes (SLR was normal) (GO to Strength (2n.) 3. No (GO to Strength (2n).
If 2m=1	2m(1). If abnormal, was it confirmed in another body position?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2n. Strength (if abnormal, per specific muscle groups)?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2o.Cranial Nerves?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2p. Sensation?	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2q. Deep Tendon Reflexes	1. Yes 2. No
If B2 or B4 =1,2,4,5,6,12,13,14,15,16	2r. Oriented to person, place, and/or time?	1. Yes 2. No
If B4 =1,2,4,5,6,12,13,14,15,16	2s. Rectal exam?	1. Yes 2. No
If B4 =1,2,4,5,6,12,13,14,15,16	2t. Genital abnormalities?	1. Yes 2. No
	SKIP TO SECTION M	
	3. MUSCULOSKELETAL/ORTHOPEDIC EXAM **Did the CE Report adequately address:** **GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for osteoarthritis of the knee, "sensation" does not need to be described with the same amount of detail as when the claimant alleges peripheral neuropathy. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are.**	
If B2 or B4 = 7 or 9	3a. Muscle spasm **<u>or</u>** tone (includes any comment noting spasticity, flaccidity, rigidity, softness, and/or firmness)?	1. Yes 2. No
If B2 or B4 = 7 or 9	3b. Joint ROM (including spine) **in degrees (degrees not necessary for "Yes" if ROM normal**)?	1. Yes 2. No

If B2 or B4 = 7 or 9	3c. SLR/tension signs **in degrees (degrees not necessary for No. 2.)**?	1. Yes (SLR was abnormal) 2. Yes (SLR was normal) (GO to Strength 3d) 3. No (GO to Strength (3d)
If 3c=1	3c1. If abnormal, was it confirmed in another body position?	1. Yes 2. No
If B2 or B4 = 7 or 9	3d. Strength (if abnormal, per specific muscle groups)?	1. Yes 2. No
If B2 or B4 = 7 or 9	3e. Sensation?	1. Yes 2. No
If B2 or B4 = 7 or 9	3f. Deep Tendon Reflexes?	1. Yes 2. No
If B2 or B4 = 7 or 9	3g. Muscle bulk **or** atrophy?	1. Yes 2. No
If B2 or B4 = 7 or 9	3h. Joint instability	1. Yes 2. No
	SKIP TO SECTION M **4. NEUROLOGY** **Did the CE Report adequately address:** **GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for carpal tunnel syndrome, "speech and language functions" do not need to be described with the same amount of detail as when the claimant alleges residua from a stroke. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are.**	
If B2 or B4 = 3, 3a or 8	4a. Cranial Nerves?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4b. Strength (if abnormal, per specific muscle groups)?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4c. Fatigability?	1. Yes 2. No

If B2 or B4 = 3, 3a or 8	4d. Muscle bulk ***or*** atrophy?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4e. Peripheral sensation?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4f. Cortical sensation (e.g., stereoagnosis, extinction, and/or ignoring)?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4g. Coordination?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4h. Adventitious (spontaneous, non-volitional) movements (e.g., tremors, choreoform movements, tics, tardive dyskinesias)?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4i. Deep Tendon Reflexes?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4j. Superficial reflexes (e.g., the abdominal reflex, palmomental reflex)?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4k. Pathologic reflexes (e.g., the Babinski sign, Hoffman sign)?	1. Yes 2. No
If B2 or B4 = 3, 3a or 8	4l. Speech functions? **SEE CODEBOOK for clarification**	1. Yes – at least 4 items were addressed 2. Yes – 2 or 3 items were addressed 3. Yes – 1 item was addressed 4. Yes – but there was only mention of the group of speech functions and individual functions were not referred to or discussed 5. No
If B2 or B4 = 3, 3a or 8	4m. Cognition? **SEE CODEBOOK for clarification**	1. Yes – at least 4 items were addressed 2. Yes – 2 or 3 items were addressed 3. Yes – 1 item was addressed 4. Yes – but there was only mention of the group of cognitive functions and individual functions were not referred to or discussed 5. No
If B2 or B4 = 3, 3a or 8	4n. Emotion (mood ***or*** affect)?	1. Yes 2. No

	SKIP TO SECTION M **5. OPHTHALMOLOGY** **Did the CE Report adequately address:** **GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for an allegation of cataracts, the retina does not need to be described with the same amount of detail as when the claimant alleges macular degeneration. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are.** See: http://www.uic.edu/com/eye/pdf/ophthalmic_dictionary_alphabetical.pdf for commonly used abbreviations in ophthalmology	
If B2 or B4 =10	5a. Best-corrected visual acuity (this includes use of appropriate technology for assessing young children)?	1. Yes 2. No
If B2 or B4 =10	5b. Visual field loss?	1. Yes 2. No
If B2 or B4 =10	5c. The external eye exam?	1. Yes 2. No
If B2 or B4 =10	5d. The pupils **and** pupillary responses?	1. Yes 2. No
If B2 or B4 =10	5e. Ocular motility?	1. Yes 2. No
If B2 or B4 =10	5f. A slit lamp examination of the anterior structures?	1. Yes 2. No
If B2 or B4 =10	5g. Intraocular pressure?	1. Yes 2. No
If B2 or B4 =10	5h. A funduscopic examination?	1. Yes 2. No
If B2 or B4 =10	5i. Was there a **specific comment** that the claimant's identification was verified during the physical exam?	1. Yes 2. No
If B2 or B4 =10	5j. Was ***any*** part of the ophthalmological exam recorded on a standardized form?	1. Yes 2. No
	SKIP TO SECTION M	

	6. ENT **Did the CE Report adequately address:** **GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for a peripheral hearing deficit, "the larynx" does not need to be described with the same amount of detail as when the claimant alleges vocal cord dysfunction. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are.** See: http://www.ent.ufl.edu/files/forms/Common%20ENT%20Abbreviations- Acronyms%20- %20per%20WOC%2012- 26-07.pdf for commonly used abbreviations in ENT.	
If B2 or B4 =11 or 11a	6a. The external ears?	1. Yes 2. No
If B2 or B4 =11 or 11a	6b. The external auditory canals?	1. Yes 2. No
If B2 or B4 =11 or 11a	6c. The tympanic membranes **and** middle ear?	1. Yes 2. No
If B2 or B4=11 or 11a	6d. The mastoids?	1. Yes 2. No
If B2 or B4=11 or 11a	6e. The nose **and** oral cavity?	1. Yes 2. No
If B2 or B4=11 or 11a	6f. Weber **and** Rinne tests?	1. Yes 2. No
If B2 or B4=11 or 11a	6g. The larynx?	1. Yes 2. No
If B2 or B4=11 or 11a	6h. Whether speech can be heard, understood, ***or*** sustained?	1. Yes 2. No
If B2 or B4 =11 or 11a	6i. Was there a **specific comment** that the claimant's identification was verified during the physical exam?	1. Yes 2. No
If B2 or B4 =11 or 11a	6j. Was ***any*** part of the ENT exam recorded on a standardized form?	1. Yes 2. No
	SKIP TO SECTION M	

	L. Mental Health **DID THE CE REPORT ADEQUATELY ADDRESS?** **GENERAL INSTRUCTIONS:** To be considered "adequately addressed," enough clinical detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, and if so, whether applicable Listings are satisfied, and what residual cognitive and behavioral capacities for work are. Credit should be given ("Yes" response) if the CE provider elicited the appropriate response(s) even if s/he did not immediately "analyze" the significance of the specific responses(s). The issue of analysis is considered in Sections N and O below. The information needed to evaluate the specific issues queried will be described in the body of the CE Report and/or in the results of ancillary psychological tests. The Section L question categories below do not have to be explicitly referred to by name in the CE Report in order to conclude that the particular issue was adequately elicited and/or evaluated. **We strongly suggest reviewing the Codebook for additional guidance regarding Section L questions.**	
If B1=2 or B1=4	1. Was there a **specific comment** that the claimant's identification was verified during the mental status exam?	1. Yes 2. No
If B1=2 or B1=4	2. Did the CE provider assess: general appearance, behavior, **and/or** speech? .	1. Yes - at least 2 of 3 items were addressed 2. Yes – only 1 item was addressed 3. No
If B1=2 or B1=4	. 3. Did the CE provider assess thought processes?	1. Yes 2. No
If B1=2 or B1=4	4. Did the CE provider assess thought content?	1. Yes 2. No
If B1=2 or B1=4	5. Did the CE provider assess perceptual abnormalities?	1. Yes 2. No
If B1=2 or B1=4	6. Did the CE provider assess mood **or** affect?	1. Yes 2. No

If B1=2 or B1=4	7. Did the CE provider assess cognition (i.e., concentration, memory, intellectual functioning, ***and/or*** include a mini - Mental Status exam)?	1. Yes 2. No
If B1=2 or B1=4	8. Did the CE provider assess judgment **or** insight either by directly asking a question(s) related to these capacities and/or by inferring the status of these capacities from the claimant's history? **SEE CODEBOOK FOR CLARIFICATION**).	1. Yes, based **only** on directly asking the claimant questions related to these issues. 2. Yes, based **only** on inferences from the claimant's history (e.g., substance abuse history, criminal history, interpersonal relationships, etc.). 3. Yes, based on **both** directly asking relevant questions **AND** drawing inferences from the claimant's history. **4**. No
If B1=2 or B1=4	9. Was the mental status examination independently, i.e., directly, elicited and not inferred from a written instrument?	1. Yes , 2. No
If B1=2 or B1=4	10. Was the CE performed through a video conference?	1. Yes 2. No
If B1=2 or B1=4	11. Was any part of the Mental Status exam recorded on a standardized form?	1. Yes 2. No
	M. Lab Studies/X- rays/Tests	
	GENERAL INSTRUCTIONS: Consider here ONLY those lab tests, psychological/cognitive tests, and/or X- rays that were either ordered by SSA and actually performed by the clinical CE provider or, if ordered separately by SSA, were expected to be available (i.e., the results) to the CE provider for inclusion into the clinical CE provider's case discussion/analysis and list of diagnoses. See Codebook for instructions on how to handle tests performed by the CE provider that were not ordered by SSA.	

All	1. Were any lab tests, psychological/cognitive tests, and/or X-rays ordered **and** performed along with the clinical CE or added on during the CE?	1. Imaging studies-**only** 2. Lab studies (e.g., blood, EKG, etc.)-**only** 3. **Both** imaging and lab studies 4. Psychological studies (**INCLUDE** subjective psychological instruments (e.g., MMPI); **INCLUDE** objective tests (e.g., WAIS); **EXCLUDE** MENTAL **(and mini- Mental)** STATUS EXAMs) 5. No (Go to Section N)
If M1=1, 2, 3, or 4	2. Were any of the tests not compliant with requirements in the Listings of impairments?	1. Yes 2. No
If M2=yes	2a. List the type of noncompliant study(s)	1._____ 2._____
If M1=1, 2, 3, or 4	3. Did the CE provider discuss the test results in the CE Report you are reviewing?	1. Yes 2. No 3. CE provider did not have these results available when the CE Report version you are reviewing was generated.
If M1=1, 2, 3, or 4	4. Was ***any*** lab test, psychological/cognitive tests, and/or X-ray, etc., associated with the CE Report ***you are reviewing*** unnecessary for adjudication?	1. Yes 2. No (Go to M5)
If M4=1	a. List the type of unnecessary procedure/test(s):	1. _____ 2. _____ 3. _____
If M1=1, 2, 3, or 4	5. Did the Worksheet note that the additional ancillary study needed was of a specialized ***or*** highly technical nature?	1. Yes 2. No
	N. CE Report Assessment by Medical Consultant.	
	GENERAL INSTRUCTIONS: In this section you are asked to make assessments based on the data provided in the Medical History, objective examination (Physical or Interview as appropriate), and any ancillary studies.	
All	1. Did the CE provider include a discussion of the CE findings (from the Medical History and either the Physical or Mental Status Examination)?	1. Yes 2. No

All	2. Was a reasonable diagnosis provided for each distinct allegation/impairment that was evaluated by the CE provider?	1. Yes – for all of them 2. Yes – For at least 1/2 of the allegations, but not for all of them 3. Yes – For some (less than 1/2) of the allegations 4. No, not for any allegations
All	3. Were all allegations that SSA intended evaluation of **in this CE** addressed by the CE provider?	1. Yes 2. No
All	4. Were all allegations or impairments that were evaluated or listed by the provider in the CE Report previously known to SSA (Form 3368, 3820, MER, or elsewhere)?	1. Yes 2. No
All	5. Did the CE findings support **EVERY** diagnosis made by the CE provider?	1. Yes 2. No
All	6. Was a prognosis provided?	1. Yes 2. No (Go to N8)
If N6=Yes	7. Was the prognosis supported by the CE findings?	1. Yes 2. No
All	8. Were the CE findings and conclusions generally consistent with the MER **related** to the issues evaluated in the CE?	1. Yes 2. No 3. There was no MER **related** to the issues evaluated in this CE
All	9. Was there an indication of a change in the applicant's condition that ***potentially could have*** affected his/her adjudicative status?	1. Yes 2. No
Initial level	10. **In your opinion**, based on MER in the E-file **at the time the CE was ordered**, was the CE needed to adequately evaluate the issues addressed at the CE for adjudication purposes?	1. Yes 2. No
If hearings level	11. Do you agree with the ALJ that the MER (including any prior CE's) was not sufficient to support a claim decision without ***your*** current CE?	1. Yes 2. No
All	12. Did MER **related to the issues evaluated in *your*** CE appear after ***your*** CE was performed?	1. Yes 2. No

If N12=Yes	13. In **your** opinion, would the "late-arriving" MER have made ***your*** clinical ("hands-on") CE unnecessary?	1. Yes 2. No 3. I already had concluded the CE was unnecessary.
ALL	14. Were ***any*** CE's performed at an **earlier** adjudicative level in the claim process **(check no for initial claims)**? **NOTE:** This question is **NOT** limited to CE's in **your** specialty! This question **INCLUDES** CE's from prior applications that have been incorporated into eView.	1. Yes 2. No (GO to SECTION O)
If N14=1	15. If so, what were the ALJ's **STATED reason(s)** (in his/her OPINION) for requesting ***your*** CE?	1. Because (answer a, b, c, d, ***and/or*** e as appropriate) a. Because a new impairment was alleged (in a newly implicated or previously implicated body system) b. Because of outdated MER or a change in the status of a previously alleged impairment c. Because of a conflict in supporting MER information d. Because a different type of specialty or subspecialty exam was sought to evaluate a previously evaluated allegation, e.g., an orthopod, as opposed to an internist, to evaluate previously alleged low back pain e. Because of any other **STATED** reason. 2. ALJ did not state ***any*** reason for ordering ***your*** CE

If N14=1	16. Was the most recent prior CE from an earlier decision (**ANY SPECIALTY**!) within 6 months of the date the ALJ ordered **your** CE?	1. Yes 2. No
If N14=1	17. If the earlier CE was in **your** specialty, what was the overall quality of the **earlier** CE Report (use response 4 if not within your CE's specialty)?	**1. Materially deficient CE Report: needed correction.** The earlier CE Report contained **critical** errors and/or omissions. These rendered the Report not fully usable - without additional information - for evaluating the claimant's allegations *at the time the earlier CE was performed*. **2. Average quality CE Report: could be used to adjudicate the claim.** The earlier CE Report provided SSA with the data needed to adjudicate the claim properly; **BUT** the CE Report contained **non- critical** deficiencies (errors and/or omissions) compromising its overall quality. **3. High quality CE Report.** The earlier CE Report included all or most of the items and details that SSA could reasonably expect from this CE purchase. **4. Not relevant: different CE type.** All earlier CE's were not of the same specialty type as *your* CE.
	O. Medical Source Statements involving Functional Capacities or Childhood Domains (Adults/Children)	
All	**GENERAL INSTRUCTIONS: A Medical Source Statement (MSS) is expected in all CE Reports. Might be at end of CE Report or on a separate sheet within CE Report file, or in a separate document in eView, e.g., might also be associated with a different version of the CE Report you are reviewing. If on a separate sheet, will often utilize a stylized format, i.e., a pre- printed chart or table format.** 1. Was a there a medical source statement (MSS) on a separate form in eView (same document as CE or in a separate document)?	1. Yes 2. No

If B2 = 1,2,3,3a,4,5,6,7,8,9,12,13,14,15,16	2. Which of the following functional capacities were estimated for an adult physical CE whether on a separate Form or at the end of the Medical History/Physical Exam, i.e., in the discussion or as a separate statement/list?	
If O2 = Yes	2a. Sit (for how long)	1. Yes 2. No
If O2 = Yes	2b. Stand (for how long)	1. Yes 2. No
If O2 = Yes	2c. Walk (for how long or how far or how often)	1. Yes 2. No
If O2 = Yes	2d. Lift (how much)	1. Yes 2. No
If O2 = Yes	2e. Carry (how much)	1. Yes 2. No
If O2 = Yes	2f. Handle/finger objects	1. Yes 2. No
If O2 = Yes	2g. Hear	1. Yes 2. No
If O2 = Yes	2h. Speak	1. Yes 2. No
If O2 = Yes	2i. Travel	1. Yes 2. No
If B1 = 2	3. Which of the following functional capacities were estimated for an adult Mental Health CE whether on a separate form or at the end of the Medical History/Mental Status Exam, i.e., in the discussion or as a separate statement/list?	
If O3 = Yes	3a. Understanding and memory	1. Yes 2. No
If O3 = Yes	3b. Concentration, persistence, and pace	1. Yes 2. No
If O3 = Yes	3c. Social Functioning	1. Yes 2. No
If O3 = Yes	3d. Adaptation	1. Yes 2. No
If O3 = Yes	3e. Capability of handling funds	1. Yes 2. No

If B1 = 3 or B1 = 4	4 – Which of the following functional abilities were described relative to children of the same age with no impairment? **NOTE:** If the CE related to the specialty of Speech Language Pathology, only domains 4a and 4c below are applicable. Therefore, for this type of CE, 4b, 4d, 4e, and 4f should **ALWAYS** be answered "No."	
If O4 = Yes	4a. Acquiring and using information (hearing, communicative ability)	1 Yes 2 No
If O4 = Yes	4b. Attending and completing tasks (attention span, follow directions)	1 Yes 2 No
If O4 = Yes	4c. Interacting and relating with examiner (orientation, affect/behavior)	1 Yes 2 No
If O4 = Yes	4d. Moving about and manipulating objects (gross and fine motor skills)	1 Yes 2 No
If O4 = Yes	4e. Caring for self (personal grooming as relevant for age)	1 Yes 2 No
If O4 = Yes	4f. Health and physical well-being (physical health and medical needs)	1. Yes 2. No
	P. Overall Completeness of CE Report	
All	1. Was the CE report signed by an acceptable medical source (provider) who **actually performed** the CE?	1. Yes (actual signature, electronic signature, stamp or surrogate) 2. No (unsigned)
All	2. What is the overall quality of the CE Report **you are primarily reviewing**?	**1. Materially deficient CE Report: needed correction.** The CE Report contained critical errors and/or omissions. These rendered the Report not fully usable – without additional information - for evaluating the claimant's allegations. information **2. Average quality CE Report: could be used to adjudicate the claim.** The CE Report provided SSA with the data needed to adjudicate the claim properly; **BUT** the CE Report contained multiple **non- critical** deficiencies (errors and/or omissions) compromising its overall quality. **3. High quality CE Report.** The CE Report included all or most of the items and details that SSA could reasonably expect from this CE purchase.

All	3. Please **also** assess overall CE Report quality according to the following summary and 5-point scale: **The CE Report contained all of the information (expected findings, conclusions, and responses to specific SSA questions) that SSA "paid for."**	1. Strongly disagree. 2. Disagree 3. Neither agree nor disagree 4. Agree 5. Strongly Agree

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APPENDIX B:

CONSULTATIVE EXAMINATIONS TEMPLATE CODEBOOK CONTENTS DEVELOPED BY DESIGN TEAM

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CONTENTS

OVERVIEW FOR MEDICAL CONSULTANTS OF HOW TO LOCATE CE REPORT FILES

Initial Claims

- Find the file count number located in the header section (top of each page) of the MPR data collection tool at the MPR Website.
- In the permanent Medical Record Section of the E-file (under the Lower Yellow heading), count *all* documents down from the top most document in the INITIAL CLAIM **group** of documents. (Do *not* count "IN" claims that are located within the RC, HR, or AC document sections of the E-file.)
- For purposes of completing MPR's Web-based data collection tool, ONLY "analyze" the CE Report document that corresponds to this count number. Do not "analyze" any other CE Report document in the E-file no matter where it resides. BUT: you will need to review as MER – not "analyze" – other CE Reports in the record to answer some TEMPLATE/WEBSITE questions. Contact COMS (716-692-6541) if a CE Report appropriate for your review does not correspond to the file count number.

ALJ Claims

- In order to locate the appropriate ALJ (ODAR) CE Report document for your analysis, find the file count number located in the header section (top of each page) of the MPR data collection tool at the MPR Website.
- This number should be applied as follows: count all documents down from the top most document in the HR (ODAR) **group** of documents regardless of whether or not each document counted is labeled "HR.". Do not count "HR" documents that are located within the AC document group or elsewhere in the E-file (IN or RECON).
- Analyze the CE Report document that corresponds to this count number. Do not analyze any other CE Report document in the record (even another version of the same CE Report) no matter where it resides in the HR document group. BUT: you will need to review other CE Reports in the E-file as MER.
- The ALJ's opinion will appear as a document in the Section of the E-file related to claim decisions (including Form 831's) (Top Section of the E-file, i.e., the Upper Yellow Section). Contact COMS (716-692-6541) if a CE Report appropriate for your review does not correspond to the file count number.

NOTE: FOR BOTH IN AND HR DECISIONS

- **A**n appendage to a CE Report you are reviewing might appear as a separate document in eView or as part of another version of the CE Report you are reviewing. You might have to therefore open another CE Report document to get to the appendage to review it. BUT if you do so, **ONLY ANALYZE YOUR CURRENT CE REPORT REGARDING DIAGNOSIS, DISCUSSION, ETC. In other words, the Analysis Section of the CE version with an added Lab/X-ray/Psychological Report might be "more complete" than your version. Nevertheless, analyze your version only as to the contents and quality of CE Report discussions/conclusions.**

1. SECTION C WORKSHEET REVIEW

GENERAL INSTRUCTIONS:

- In Section C, all questions refer **only** to the Worksheet. For **BOTH** INITIAL decision cases **AND** ALJ cases, attempts must be made to locate the **CORRESPONDING** Worksheet.
- **Permanent Medical Record (Lower Yellow) Section:** First, check the Lower Yellow Section of the E-file that contains permanent medical records (MER, etc.) for a Worksheet. (Note: the claim decision is under a *different* Yellow Heading, which is located at the top of the E-file main document page.) Make sure the Worksheet covers the decision level that you are reviewing (it should be labeled IN or HR, as appropriate). Use the LATEST (most complete) version of the Worksheet (highest on the screen) *for this decision level.*
- **Developmental (Blue) Section:** If there is no Worksheet under the Lower Yellow Heading for the decision level you are reviewing, look for it in the Blue Section (Claim Development documents, located higher in the file). The Worksheet can be in one of several different formats across the United States: LEVY (most common), VERSAR (second most common), state unique (CA, NY, etc.)

Item Number	Question	Response Options
1.	Was a DDS worksheet for **THE DECISION LEVEL OF *YOUR* CE** (INITIAL OR ALJ) in the E-file?	1. Yes 2. No (Go to Section G)
Where to find:	**Worksheet** (most recent (highest) in Lower Yellow Section; might be in Blue Section)	
How to code:	• Code as "Yes" if a DDS Worksheet for the **APPROPRIATE** decision level was found, i.e., if the decision level for the CE is INITIAL then there is a DDS Worksheet in the INITIAL portion of eView, whereas if the decision level for the CE is ALJ, then there is a DDS Worksheet in the ALJ (labeled HR) portion of eView. • Code as "No" if a DDS Worksheet for the **APPROPRIATE** decision level was *not* found.	
2.	Was ***any*** reason given on ***your*** Worksheet for ordering ***your*** CE?	1. Yes 2. No (Go to Section G)
Where to find:	**Worksheet comments**	
How to code:	• Code as "Yes" if a reason is given for ordering the CE, e.g., "need new development of - or updated status - regarding "shortness of breath" or "frequency of depressive episodes" or "frequency of severe asthma attacks;" OR "there is a conflict in the MER regarding "severity of knee pain," OR "MER is insufficient to adjudicate claim," etc. • Code as "No" if there is no information or reason, even a general one such as "insufficient MER, in the Worksheet describing **why** the CE	

	was requested. **NOTE: On VERSAR Worksheets only, in the area of the Worksheet where purchase of the CE is documented, sometimes a comment such as "No treating source" will have been recorded. FOR THIS TYPE of WORKSHEET and in THIS LOCATION ONLY, this comment often refers to the fact that a treating source was NOT AVAILABLE to perform the CE, and is NOT the reason why the CE was ordered. A CE is purchased because the medical evidence in the file is not sufficient for a valid claim decision. This examiner conclusion will be documented in the (freehand) Comments Section. Only here, should a comment like "No treating source" be interpreted as a reason for ordering the CE if it appears the examiner really meant "no or inadequate treating source evidence."**	
3.	Did the Worksheet note that the CE was ordered to obtain more recent evidence?	1. Yes 2. No
Where to find:	**Worksheet comments/entries**	
How to code:	• Code as "Yes" if one reason noted for ordering the CE was that available MER was not felt to be timely. • Code as "No" if timeliness of available MER was NOT mentioned as a reason for ordering the CE. (Hopefully, another MER scenario was described (e.g., the MER was conflicted, or there was an insufficient amount of relevant MER).	

2. SECTION G: MEDICAL EVIDENCE DOCUMENTATION		
See GENERAL INSTRUCTIONS above (Section C) for locating the appropriate INITIAL and ALJ LEVEL CE Reports.		
Item Number	**Question**	**Response Options**
1.	Did the CE provider refer to or mention Medical Records as a group or the specific names of individual items of medical records ***in any way*** in the CE Report?	1. Yes (**EXCLUDES** CE Reports in which there was a comment that there was no MER to review) 2. Yes (**INCLUDES** *only* those CE Reports in which there was a comment that there was no MER to review (Go to Section I)) 3. No (Go to Section I)
Where to find:	**CE Report**: Typically, the CE provider writes "medical records reviewed" - or something similar – or lists the individual items reviewed - in the beginning of the CE Report. But a reference to "medical records," including the name of a specific item of MER could be noted anywhere, including at the end of the Report. If the information is not found in the Introduction to the CE Report look for it in the Medical History and Physical/Mental Status examination Sections and in text following these Sections. If the information is not found earlier in the CE Report, look for it in the Discussion/Analysis. There may be a reference there to "records" received or reviewed, etc.	
How to code:	• Code as "Yes" No. 1 if there is **any reference** in the CE Report itself that MER was received. This includes any statement implying that medical records were reviewed or that an item or list of items was reviewed. • Code as "Yes" No. 2 if the CE provider stated that there was no MER to review. • Code as "No" if there was no mention or reference to MER or an item(s) of MER from a treating source (including a treating source MSS) in the CE Report.	

2. SECTION G: MEDICAL EVIDENCE DOCUMENTATION		
2.	Did the CE provider list ***deliberately*** at least one specific item of MER he/she reviewed in the CE Report?	1. Yes (Go to Section I) 2. No (Go to Section I)
Where to find:	Typically found in the beginning of the CE Report but could be found elsewhere, as noted above.	
How to code:	• Code as "Yes" only if a specific item of MER was referred to as having been deliberately reviewed, (e.g., a chest X-ray report, or an MMPI report). • Code as "No" if the CE provider only noted summarily that "medical records were reviewed," etc. Note: the intent here is to "give credit" for having deliberately listed individual items of MER as having been reviewed. Thus, Code as "No" if the CE provider only referred to data that probably was obtained from MER, based on its "complexity," but was not deliberately listed or specifically referred to as having been reviewed as MER.	

3. SECTION I: MEDICAL HISTORY INCLUDING HISTORY OF PRESENT ILLNESS		
GENERAL INSTRUCTIONS: For the following items related to the Medical History, specific guidance is provided for each item for locating the needed information and how to approach coding the MPR Website Template.		
Item Number	**Question**	**Response Options**
1.	Did the CE provider ***specifically*** **indicate in a separate comment** who gave the medical history?	1. Yes-Claimant-only 2. Yes-Claimant and another person (e.g., parent) 3. Yes-Other person(s) only 4. No
Where to find:	**CE Report**: Usually, the source of the Medical History is noted in the beginning of the CE Report, (i.e., before the Present Illness is described).	
How to code:	• Code as "Claimant-only" if there is a **separate comment** describing who gave the medical history, e.g., "The history was given by the claimant." **DO NOT INFER** who gave the history simply because the CE provider stated "The claimant said, etc." or used other third person "active" language. **Note:** the POMS stipulates that the CE provider is to *indicate who gave the Medical History*). Especially for children, a parent could have given 95% of the medical history, and for one comment, the CE provider might have said, "The claimant said …," etc. • Code as "Claimant-only" if only a language interpreter assisted the claimant. • Code as "No" if the source of the medical history is not explicitly mentioned in a separate comment.	
2.	Was there a ***specific comment*** in the CE Report about the reliability of the medical history?	1. Yes 2. No
Where to find:	**CE Report:** Comments about the reliability of the Medical History are often in the beginning of the CE Report, but may be at the end in the discussion of CE results.	
How to code:	• Code as "Yes" only if the CE provider has included a **specific statement** describing the validity of the claimant's medical history. Stating that the claimant was cooperative and friendly is not sufficient for concluding that the history given by the claimant (or someone else) was valid in the opinion of the CE provider.	
3.	Per Study definition, was there a Chief Complaint?	1. Yes 2. No (Go to I4)
Where to find:	Define the Chief Complaint - ***for purposes of***	

	this Study - as follows: 1. Look at the Primary Diagnosis on the Form 831 **for the appropriate decision level (Initial or ALJ).** 2. If there is one or more Chief Complaints listed by the CE provider, select the first listed Chief Complaint that corresponds to the 831 **Primary** Diagnosis. ("Corresponds" means that a symptom relating to the 831 diagnosis was evaluated in *your* CE.) 3. If there is no listed Chief Complaint that corresponds to the **Primary** 831 Diagnosis, select the first item discussed *to any extent* by the CE provider in the History of Present Illness *if your CE corresponded to the 831 Primary Diagnosis.* Note: As an example, y*our* CE would *not* correspond to the 831 Primary Diagnosis if your CE was for chronic low back pain (e.g., an IM or Musculoskeletal CE) and the 831 Primary Diagnosis was schizophrenia. 4. If you have not as yet defined a Chief Complaint, repeat steps 1-3 for the **Secondary** Diagnosis on the 831. 5. If you still have not defined a Chief Complaint (i.e., *your* CE does not relate to either the **Primary** or **Secondary** Diagnosis on the **APPROPRIATE DECISION** level 831, for purposes of this study), presume there is **no Chief Complaint**, **even if the CE provider listed a specific Chief Complaint unrelated to the 831**. 6. If **you are reviewing a HEARING LEVEL (ALJ/ODAR) decision**, and there are **no 831 diagnoses *at all* for this decision level**, read the ALJ's opinion. Identify what precisely were the ALJ's **Primary** and **Secondary** diagnoses *for the claim as a whole. Only if it is clear in the ALJ's opinion what were these two categories of diagnosis*, repeat steps 2, 3, and 4 above.	

	7. **If it is unclear** what the ALJ's **Primary** and **Secondary** Diagnosis were *for the claim as a whole* (**and it will be UNCLEAR very often!!**), review the **Primary** and **Secondary** Diagnoses for the most recent 831 in the E-file and repeat steps 2, 3, 4, and 5 above. (**The most recent 831 might be from the RECON level**.) **Note:** Only attribute a **Primary** and **Secondary** Diagnosis to the ALJ if the opinion refers to specific diagnoses as such or uses very similar descriptors. However, if the ALJ only discusses one diagnosis in your specialty area, you may presume it is the Primary diagnosis for Chief Complaint purposes. However, if the ALJ discusses two or more diagnoses in your specialty area, one of these must be designated **Primary**, and, if that doesn't relate to *your* CE, another must obviously be the Secondary one in order to use an ALJ diagnosis as a Chief Complaint. **Note:** *Per these rules*, there will be cases ***without any*** Chief Complaint. (e.g., when *your* CE was ordered to rule out a specific severe impairment, the impairment was in fact ruled out, and, consequently, there was no 831 diagnosis related to the results of *your* CE).	
How to code:	• Code as "Yes" if you identified a Chief Complaint per the above procedure. • Code "No" if the above procedure fails to establish a Chief Complaint **for Study purposes.** **Note:** There will be instances when a Chief Complaint **does not exist** per STUDY DEFINITION, **even though** the CE provider **identified a Chief Complaint**!	
3a.	3a. Was the Chief Complaint clarified (differential diagnosis explored or a diagnosis confirmed)?	1. Yes 2. No
Where to find:	**History of Present Illness and Review of Systems:** "clarified" is meant here to describe the process by which the CE provider asked about pertinent positive and negative symptoms and diagnoses that would be expected to clarify and establish the specific nature of the claimant's	

	impairment(s). This question is **NOT** asking about severity, ***original*** onset, and functional implications, which are all addressed in separate questions below. If the Chief Complaint was a specific diagnosis, e.g., diabetes or schizophrenia, this questions refers to the process by which the CE provider confirmed it**.** **Note:** To the extent that the duration of episodes (exacerbations) of an illness helps to clarify diagnosis, duration of episodes is part of "clarified" (i.e., this question).	
How to code:	● Code as "Yes" if the Chief Complaint was "clarified" per the above definition. Do not consider severity, onset, and functionality in reaching this conclusion. ● Code as "No" if the Chief Complaint was not "clarified per the above	
3b.	Was ***any*** information provided that reflected on the severity of the Chief Complaint-related medical condition? **Note:** Consider information about functional consequences, including ADL's, as clarifying severity.	1. Yes 2. No
Where to find:	**History of Present Illness:** Severity can be inferred from descriptions of symptom intensity, symptom duration, and/or symptom frequency. Severity might also be inferred from effects on functional capacities (lift, carry, interpersonal skills). Read this entire CE section for ***any comment*** that explicitly addresses or implicitly implies how severe, intense, good/bad, comfortable/uncomfortable, etc., the particular Chief Complaint issue is. Remember, the Chief Complaint might represent a symptom (e.g., chest pain or shortness of breath) or a diagnosis (e.g., diabetes). **Note:** To the extent that the duration of episodes (exacerbations) of an illness helps to clarify severity of an illness, duration of episodes is part of "severity" (i.e., this question).	
How to code:	• Code as "Yes" if the "severity" of the Chief Complaint was addressed to any extent per the above criteria. • Code as "No" if the "severity" of the Chief Complaint was not described per the above criteria.	
3c.	Was the approximate time of onset of the Chief Complaint-related medical condition described?	1. Yes 2. No 3. Birth or before

Where to find:	**History of Present Illness and Review of Systems.** Look for a description of when the Chief Complaint-related medical condition first began; this can be the year (or number of years ago), the month (or number of months ago), or the specific date. Do **not** just determine when the **last** episode/attack began if the Chief Complaint condition is intermittent. If the onset is less than one year from the CE date, it should be possible to estimate the month of onset.	
How to code:	• Code as "Yes" if the approximate time of onset for the Chief Complaint was discussed per the above criteria. • Code as "No" if the approximate time of onset of the Chief Complaint could not be inferred. • Code as "Birth or before" if time of onset was not explicitly noted, but it was obvious the onset was at or before birth.	
3d.	Was anything that made the Chief Complaint-related medical condition better (including treatment) or worse described? **NOTE: This question is *NOT* asking about what initially caused or led to the development of the Chief Complaint-related diagnosis, *or* what its initial Rx was.**	1. Yes 2. No
Where to find:	**History of Present Illness**: Look for language about what improves the Chief Complaint-related medical condition (e.g., rest, oxygen, sleep, etc.). Consider maintenance or episodic/symptomatic RX as an improving or remitting factor (e.g., metoprolol BID, a beta-agonist inhaler as needed, etc.). Also, look for language about what aggravates or worsens the Chief Complaint-related medical condition (e.g., climbing stairs, spousal arguments, isolation, etc.). Consider a description of maintenance or symptomatic RX as a remitting factor **ONLY IF it is described** in the History of Present Illness, Review of Systems, or the Sections on Impressions, Conclusions, and or the Discussion (e.g., a beta-agonist inhaler as needed, or use of an assistive device, or periodic psychotherapy, etc.)**, and not if it is only listed in the Medication Section**.	
How to code:	• Code as "Yes" if at least one worsening ***or*** remitting factor was discussed for the Chief Complaint-related medical condition. • Code as "No" if this topic was not addressed for the Chief Complaint-related medical condition.	

	The following I4 questions are based on any **OTHER** allegation(s) or complaint(s) that are **NOT** due to the Chief Complaint-related medical condition.	
4.	Were there any allegations or complaints possibly related to any medical condition, diagnosis, impairment, or process that was **not** related to the Chief Complaint as you have defined it for this Study?	1. Yes 2. No (Go to I5)
Where to find:	**Entire CE Report (all Sections of the Medical History, the objective exam, and any ancillary test results):** Determine if there were there ***any other*** allegations or complaints distinct from the Chief Complaint-related medical condition, **but within the purview of the specialty of the CE *you are reviewing*** that were or should have been evaluated by the CE provider. **NOTE:** In answering this question, the Chief Complaint-related medical condition should be fairly narrowly defined. For example, a claimant could allege chronic liver disease from a primary process, e.g., alcohol-related, or could suffer from severe liver disease on the basis of a complication of severe heart failure. Because severe liver disease can be evaluated under the GI Listing, no matter what its etiology is, in the latter instance, the presence of an allegation possibly related to liver disease should be considered separate from (and in addition to) a cardiac- or pulmonary-related Chief Complaint. For a mental health-related example, consider the claimant with a Chief Complaint of a "disabling" (generalized) anxiety disorder. If the claimant also alleges "panic attacks," the latter should be considered a separate clinical diagnosis **for purposes of this question** unless review of the overall record clearly suggests that the "panic attacks" are merely one type of manifestation of the anxiety disorder. In summary, if it remains unclear whether or not a clinical issue separate from the Chief Complaint-related medical condition exists for purposes of this question, resolve such situations by concluding a second issue **is** present, especially if evaluation	

	under a different Body System is appropriate.	
How to code:	• Code as "Yes" if there is a clinical issue separate from the Chief Complaint-related medical condition – per the above definition - that the CE provider evaluated or was within the purview of the specialty of the CE provider. • Code as "No" if the Chief Complaint-related medical condition, narrowly defined, is the only clinical allegation or complaint relevant to ***your*** CE.	
4a.	4a. Was at least one other allegation **not** related to the Chief Complaint (CC)-related medical condition clarified (differential diagnosis explored or a diagnosis confirmed)?	1. Yes 2. No
Where to find:	**History of Present Illness and Review of Systems:** "clarified" is meant here to describe the process by which the CE provider asked about pertinent positive and negative symptoms and diagnoses that would be expected to clarify and establish the specific nature of one of the claimant's non Chief Complaint-related impairment(s). This question is **NOT** asking about severity, ***original*** onset, and functional implications, which are all addressed in separate questions below. If the non Chief Complaint-related allegation was a specific diagnosis, e.g., diabetes or schizophrenia, this question refers to the process by which the CE provider confirmed it**.** **Note:** To the extent that the duration of episodes (exacerbations) of an illness helps to clarify diagnosis, duration of episodes is part of "clarified" (i.e., this question).	
How to code:	• Code as "Yes" if at least one non Chief Complaint-related allegation was "clarified" per the above definition. Do not consider severity, onset, and functionality in reaching this conclusion. • Code as "No" if this issue was not "clarified" per the above for any non Chief Complaint-related condition.	

4b.	Was ***any*** information provided that reflected on the severity of at least one "non CC" allegation or possible impairment? **Note:** Consider information about functional consequences, including ADL's, as clarifying severity.	1. Yes 2. No
Where to find:	**History of Present Illness:** Severity can be inferred from descriptions of symptom intensity, symptom duration, and/or symptom frequency. Severity might also be inferred from effects on functional capacities (lift, carry, interpersonal skills). Read this entire CE section for ***any comment*** that explicitly addresses or implicitly implies how severe, intense, good/bad, comfortable/uncomfortable, etc., the particular "non Chief Complaint" issue is. Remember, the issue might represent a symptom (e.g., chest pain or shortness of breath) or a diagnosis (e.g., diabetes). **Note:** To the extent that the duration of episodes (exacerbations) of an illness helps to clarify severity of an illness, duration of episodes is part of "severity" (i.e., this question).	
How to code:	• Code as "Yes" if the "severity" of the "non Chief Complaint" issue was addressed to any extent per the above criteria. • Code as "No" if the "severity" of the "non Chief Complaint" issue was not described per the above criteria.	
4c.	Was the approximate time of onset of at least one "non CC" allegation or possible impairment described?	1. Yes 2. No 3. Birth or before
Where to find:	**History of Present Illness and Review of Systems.** Look for a description of when the "non Chief Complaint" issue first began; this can be the year (or number of years ago), the month (or number of months ago), or the specific date. Do **not** just determine when the **last** episode/attack began if the issue is intermittent. If the onset is less than one year from the CE date, it should be possible to estimate the month of onset.	
How to code:	• Code as "Yes" if the approximate time of onset for the "non Chief Complaint" issue was discussed per the above criteria. • Code as "No" if the approximate time of onset for the "non Chief Complaint" issue could not be inferred. • Code as "Birth or before" if time of onset was not explicitly noted, and it was obvious the onset was at or before birth.	

4d.	Was anything that made any "non CC" allegation or possible impairment better (including treatment) or worse described? **NOTE: This question is *NOT* asking about what initially caused or led to the development of the "non CC"-related diagnosis, *or* what its initial Rx was.**	1. Yes 2. No
Where to find:	**History of Present Illness**: Look for language about what improves symptoms or the "diagnosis" (e.g., rest, oxygen, sleep, etc.) related to the "non Chief Complaint" issue. Consider maintenance or episodic/symptomatic Rx as an improving or remitting factor (e.g., metoprolol BID, a beta-agonist inhaler as needed, etc.). Also, look for language about what aggravates or worsens the issue (a symptom or a "diagnosis" (e.g., climbing stairs, spousal arguments, isolation, etc.). Consider a description of maintenance or symptomatic Rx as a remitting factor **ONLY IF it is described** in the History of Present Illness, Review of Systems, or the Sections on Impressions, Conclusions, and or the Discussion (e.g., a beta-agonist inhaler as needed, or use of an assistive device, or periodic psychotherapy, etc.)**, and not if it is only listed in the Medication Section**..	
How to code:	• Code as "Yes" if at least one precipitating **or** remitting factor for the "non Chief Complaint" issue was described. • Code as "No" if this topic was not addressed for the "non Chief Complaint" issue.	
5.	Was there a history of inpatient and outpatient diagnostic/treatment experiences related either to the Chief Complaint-related medical condition or to a "non CC" allegation or possible impairment?	1. Yes 2. No
Where to find:	**All Medical History Sections of the CE Report**: Look for details about how the allegations at issue were clinically diagnosed or treated on an ongoing basis.	
How to code:	• Code as "Yes" if the CE provider offered clinical diagnostic or treatment details for the Chief Complaint-related medical condition or for a "non Chief Complaint"-related medical condition. These details should include information on how the claimant had been managed previously, especially for the previous 6 months to a year, so that SSA can determine the type(s) of treatment given, the success/failure of treatment, any complications of treatment, and whether the claimant followed reasonable medical recommendations. • Code as "No" if sufficient clinical details were not provided for any allegation so that an informed claim decision could not have been made.	

6.	Was at least part of the Medical History described in narrative format (i.e., was the Medical History **not** solely a checklist)?	1. Yes 2. No
Where to find:	**History of Present Illness.** Look at the description of the Medical History. Was it at least in part in narrative format (i.e., **not** solely a checklist!)? Note: Part of the Medical History might be provided on a separate pre-printed standardized form with listed items to be addressed (filled-in), e.g., MEDICATIONS, PAST MEDICAL HISTORY, ALLERGIES, ADL's, etc. However, this question asks if there was at least some of the Medical History that was described in narrative text. Narrative text would be "Hx of DOE X 4 yrs relieved by 15 min rest – OR – the claimant has a history of dyspnea on exertion for the past four years relieved by sitting down for fifteen minutes. It would **NOT** be: "checking" the "Yes" response next to a box labeled DOE Y/N. on a form. Narrative text could be entered on a form in "blank" space.	
How to code:	• Self-explanatory.	

4. SECTION J: ADDITIONAL MEDICAL HISTORY: DID THE CE REPORT ADEQUATELY ADDRESS		
GENERAL INSTRUCTIONS: Be alert for the following items to be either in a separate section of the Medical History after the History of Present Illness, or included within the History of Present Illness, or somehow otherwise combined with other items.		
Item Number	**Question**	**Response Options**
1. (**EXCLUDE FOR MENTAL HEALTH CE's**)	Was a Review of Systems documented?	1. Yes 2. No
Where to find:	**Review of Systems (ROS) Section of Medical History:** Some or all of the ROS information might be described **within the History of Present Illness**, as opposed to a **separate (later) section** of the CE Report.	
How to code:	• Code as "Yes" if the CE included **<u>any</u>** comments related to a Review of Body Systems **<u>not evaluated in the History of Present Illness</u>**. –***<u>OR</u>***- • Code as "Yes" if the CE included any reference (presence or absence) to symptoms typically associated with **<u>any</u>** of the primarily alleged symptoms or diagnoses. **Note:** "Associated symptoms" are essentially "pertinent positives" and "pertinent negatives" for purposes of establishing a differential diagnosis. • Code as "No" if a ROS was skipped.	
2.	Were any medications listed **anywhere** in the CE Report?	1. Yes 2. It was noted that no medication was being taken. (Go to J3) 3. No (Go to J3)
Where to find:	Typically, found in a separate Section in the Medical History after the History of Present Illness, but might be included within the History of Present Illness. If some medications are listed, Code as "Yes;" there is essentially no way to know if others were omitted, especially nonprescription meds.	
How to code:	• Code as "Yes" if *any* medications are listed anywhere in the CE Report. • Code No. 2 (It was noted …") if the CE Report noted that no medications were being used. • Code as "No" if no medications were listed anywhere and Response No. 2 doesn't apply.	

4. SECTION J: ADDITIONAL MEDICAL HISTORY: DID THE CE REPORT ADEQUATELY ADDRESS		
2a.	Was at least one dose regimen noted? **Note:** A dose regimen = dose **+ dose schedule** (e.g., " 50 mg. **BID**")	1. Yes 2. No
3.	Did the CE provider inquire about a history of use of alcohol and/or illicit substances?	1. Yes – for **both** alcohol **and** illicit drugs.) 2. Yes – for alcohol **only**. 3. Yes – for illicit drugs **only**. 4. No
Where to find:	The history of use of any substances of abuse might be in a separate Section of the Medical History after the History of Present Illness, or might be part of the History of Present Illness (especially in Mental Health CE's). It could also be in the Social/Work/School History, Past Medical History, or Review of Systems.	
How to code:	• Code Responses 1, 2, **or** 3 as appropriate. • Code as "No" only if 1, 2, **and** 3 do not apply.	
4.	Was the past medical history (PMH) noted?	1. Yes 2. No
Where to find:	This information is typically in a separate Section after the History of Present Illness, but might be included within the History of Present Illness.	
How to code:	• Code as "Yes" if the CE describes at least 1 of the following: prior illnesses, injuries, procedures (excluding dental and minor procedures), and/or hospitalizations. • Code as "No" if no item in any one of the above categories is described.	
5.	Was the pre-kindergarten growth and development history noted?	1. Yes 2. No 3. Reached kindergarten age
Where to find:	This type of information might appear in its own Section, in the History of Present Illness, or anywhere else in the Medical History. **Note:** This question relates ***ONLY*** to pre-kindergarten age children.	

4. SECTION J: ADDITIONAL MEDICAL HISTORY: DID THE CE REPORT ADEQUATELY ADDRESS		
How to code:	• Code as "Yes" if described in enough detail to not compromise claim adjudication. • Code as "No" if above criterion not met, i.e., there are details not in the CE Report that should be, i.e., the examiner would need to know them. ● Code as "reached kindergarten age" for children old enough to attend kindergarten.	
6.	Was the work/school history noted?	1. Yes 2. No 3. Pre-kindergarten age
Where to find:	This type of information might appear in its own Section, in the History of Present Illness, or anywhere else in the Medical History. Use this question also for the growth/development history for children who have reached kindergarten age.	
How to code:	• Code as "Yes" if described in enough detail to not compromise claim adjudication. • Code as "No" if above criterion not met, i.e., there are details not in the CE Report that should be, i.e., the examiner would need to know them. • Code as "Pre-kindergarten age" for children who are not yet in school.	
7a. **FOR ADULT PHYSICAL CLAIMS**	Was the family medical history (FMH) noted?	1. Yes 2. No
Where to find:	This information is typically found in a separate Section of the Medical History, but might be found in the History of Present Illness when relevant to the claimant's diagnosis.	
How to code:	• Code as "Yes" if the FMH was noted or if it was stated that the FMH was not relevant to the diagnosis, functional severity level, etc. • Code as "No" if the FMH was not noted or alluded to.	

4. SECTION J: ADDITIONAL MEDICAL HISTORY: DID THE CE REPORT ADEQUATELY ADDRESS		
7b. **FOR CHILDHOOD PHYSICAL AND ALL MENTAL HEALTH CLAIMS**	Was the family medical history (FMH) pertinent to the claimant's allegations noted?	1. Yes 2. No
Where to find:	This information is typically found in a separate Section of the Medical History, but might be found in the History of Present Illness when relevant to the claimant's diagnosis. "Pertinent" here is meant to relate to those elements of the Family Medical History that are specifically needed to help establish a claimant diagnosis.	
How to code:	• Code as "Yes" if the **pertinent** FMH was noted or if it was stated that the FMH was not relevant to the diagnosis, functional severity level, etc. • Code as "No" if the **pertinent** FMH was not noted or alluded to.	
8.	Was ***any*** part of the Medical History recorded on a standardized form?	1. Yes 2. No
Where to find:	Look for a pre-printed form (table or chart) **within the CE document** that has specific standard items relevant to any part of a Medical History listed on it. The expectation is that the CE provider will "fill-in" the form to record part or all of the Medical History in lieu of describing such items in a free-hand paragraph or sentence format on a "blank file sheet." **NOTE:** In rare circumstances, the "pre-printed form" might be within a SEPARATE DOCUMENT in eView	
How to code:	• Code as "Yes' if any part of the Medical History is recorded on a standardized form. • Code as "No" if all of the Medical History is recorded in free-hand paragraph or sentence format on a "blank file sheet."	

5. SECTION K1: PHYSICAL EXAM FINDINGS

GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for a cardiac allegation, "sensation" does not need to be described with the same amount of detail as when the claimant alleges peripheral neuropathy. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual functional capacities for work are. *Station/Gait and Assistive Device descriptions* are generally described in an introductory statement in the physical exam or included as a component of the exam of a particular body system (e.g., neurological, musculoskeletal, or orthopedic).

NOTE: SOME OF THE DETAILS RELATED TO SECTION K MIGHT BE LOCATED ON A SEPARATE STANDARDIZED FORM WITHIN THE CE REPORT. ALWAYS LOOK FOR SUCH AN EXTRA REPORT, ESPECIALLY FOR MUSCULOSKELETAL AND NEUROLOGICAL PHYSICAL FINDINGS AND FOR INFORMATION ABOUT ASSISTIVE DEVICE USE.

Item Number	Question	Response Options
1.	**ALL PHYSICAL EXAMS (*EXCEPT* Ophth. and ENT)**	
1a.	Was there a **specific comment** that the claimant's identification was verified at the CE?	1. Yes 2. No
Where to find:	**CE Report Introduction**: There is often an indication that identification was verified using a Drivers License, other picture ID, or unique physical attribute, etc., at the beginning of the CE Report or at the beginning of the Physical Exam section.	
How to code:	• Code as "Yes" if ID verification was **specifically** noted. • Code as "No" if ID verification was **not specifically** noted.	
1b.	Were pulse rate, blood pressure, and/or respiratory rate recorded?	1. Yes - at least 2 of 3 items were recorded 2. Yes – only 1 item was recorded 3. No
How to code:	• Code as "Yes" No. 1 if 2 of these 3 vital signs were noted: pulse rate; blood pressure; or respiratory rate. • Code as "Yes" No. 2 if only 1 of these 3 vital signs were noted: pulse rate; blood pressure; or respiratory rate.	

5. SECTION K1: PHYSICAL EXAM FINDINGS		
	• Code as "No" if no vital signs were noted.	
1c.	Was station **<u>or</u>** gait described?	1. Yes 2. No
	• Code as "Yes" if enough detail is given so that it is clear whether or not the claimant is "steady" on his/her feet, **<u>or</u>** how well the claimant moves into, out of, or about the examining room.. • Code as "No" if neither station **<u>nor</u>** gait information was described.	
1d.	Was use of an assistive device referred to in the CE Report?	1. Yes – Claimant uses an assistive device ***<u>AND</u>*** technique of use was described ***<u>AND</u>*** it is reasonable to infer that the CE provider directly observed its use. 2. Yes – Claimant alleges use of an assistive device ***<u>BUT</u>*** either the technique of use was not described, or, if it was, it was not clear, i.e., reasonable to infer, that the CE provider personally observed its use. 3. Yes – it was noted that the claimant did not use an assistive device. 4. No

5. SECTION K1: PHYSICAL EXAM FINDINGS		
How to code:	• Code as "Yes" No. 1 only if the CE provider noted how an assistive device is used based on his/her **personal observation**. For this response, do not accept claimant reports to the CE provider about how a device is used. Also, it must be clear in the description that the CE provider personally observed a demonstration of use of the device. • Code as "Yes" No. 2 if it was noted that an assistive device is used, but the CE report does not describe how the device is used or, if it does, you cannot reasonably tell if the CE provider personally observed a demonstration of its use or was just transcribing the claimant's report of how it is used. • Code as "Yes" No. 3 if it was noted that the claimant did not use an assistive device. • Code as "No" if there is no comment in the CE Report about use of an assistive device.	
1e.	Was the ability to dress/undress or other gross/fine hand functions described?	1. Yes 2. No
How to code	• Code as "Yes" if there is a description of hand **use** (fingering, writing, zipping a zipper, etc.) (**not** just testing of hand/finger strength!). • Code as "No" if hand **functions** are not described.	
1f.	Was Weight **and** Height (Length, in lieu of height, < 2 yrs.) noted?	1. Yes for (Wt. **and** Ht.) – or (Wt. **and** Length) 2. No for Wt. alone **or** Ht. alone (**or** Length alone) **or** none of these.
How to code	• Code as "Yes" if both weight **and** height were noted, or, if the claimant is less than 2 years of age, weight **and** length was noted. • Code as "No" if only weight **or** height, **or** neither, was noted; or, if the claimant is less than 2 years of age, weight **or** length, **or** neither, was noted.	

5. SECTION K1: PHYSICAL EXAM FINDINGS		
1g. CHILD PHYSICALS ONLY	Was head circumference noted?	1. Yes 2. No
1h. **CHILD PHYSICALS ONLY**	General appearance?	1. Yes 2. No
1i. CHILD PHYSICALS ONLY	Obvious vision problem?	1. Yes 2. No
1j. CHILD PHYSICALS ONLY	Obvious hearing problem?	1. Yes 2. No
1k. CHILD PHYSICALS ONLY	Facial dysmorphism?	1. Yes 2. No
1l. CHILD PHYSICALS ONLY	Skeletal abnormalities?	1. Yes 2. No
1m. CHILD PHYSICALS ONLY	Other congenital anomaly?	1. Yes 2. No
1n. CHILD PHYSICALS ONLY	Nutritional status?	1. Yes 2. No
1o.	Was ***any*** part of the physical exam recorded on a	1. Yes

5. SECTION K1: PHYSICAL EXAM FINDINGS		
	standardized form?	2. No
Where to find:	Look for a pre-printed form (table or chart) **within the CE document** that has specific standard items relevant to any part of a Physical Examination listed on it. The expectation is that the CE provider will "fill-in" the form to record part or the entire Physical Examination in lieu of describing such items in a free-hand paragraph or sentence format on a "blank file sheet." **NOTE:** In rare circumstances, the "pre-printed form" might be within a SEPARATE DOCUMENT in eView.	
How to code:	• Code as "Yes"" if part of the Physical Examination is recorded on a standardized form. • Code as "No" if the entire Physical Examination is recorded in free-hand paragraph or sentence format on a "blank file sheet."	

6. SECTION K2: GENERALIST EXAMS: DID THE CE REPORT ADEQUATELY ADDRESS?		
GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for a cardiac allegation, "sensation" does not need to be described with the same amount of detail as when the claimant alleges peripheral neuropathy. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual functional capacities for work are.		
Item Number	**Question**	**Response Options**
2a.	Was there a comment about overall claimant distress?	1. Yes 2. No
Where to find:	Typically found in introductory comment in the Physical Exam Section, but might be noted in the Respiratory Body System of the physical exam.	
How to code:	• Code as "Yes" only if there is a **specific statement** about whether the claimant is or is not in distress **OR** describing the gross level of respiratory effort. Do not infer this observation from other respiratory or other physical findings. • Code as "No" if no such **specific statement** is provided.	
2b.	Head, eyes, ears, nose, oral cavity?	1. Yes – at least 2 of 5 items were addressed. 2. Yes – only 1 item was addressed. 3. Yes – but there was only mention of the HEENT group of findings, and individual findings were not referred to or described 4. No.
2c.	Lung auscultation?	1. Yes 2. No
2d.	Cardiac rhythm?	1. Yes 2. No
2e.	Cardiac auscultation (heart sounds, murmur **and/or** gallop)?	1. Yes – at least 2 of 3 items were described. 2. Yes – only 1 item was described. 3. Yes – but there was only mention of the

		cardiac group of findings, and individual findings were not referred to or described 4. No
2f.	Abdomen: 1-liver size or spleen size or "organomegaly;" 2-bowel sounds (or bowel "benign"); 3-ascites; 4-tenderness; 5-masses)?	1. Yes – at least 3 of these 5 items were described. 2. Yes – only 1 or 2 of these 5 items were described. 3. Yes – but there was only mention of the abdominal group of findings, and individual findings were not referred to or discussed 4. No
2g.	Peripheral pulses (wrist or feet) **or** carotid strength?	1. Yes 2. No
2h.	Peripheral edema?	1. Yes 2. No
2i. **CHILD PHYSICALS ONLY**	Perspiration **or** crying?	1. Yes 2. No
2j.	Re: Joints (including spine) and any myofascial findings?	
2j(1).	effusion **or** swelling?	1. Yes 2. No
2j(2).	tenderness (includes "points")?	1. Yes 2. No
2j(3).	heat **or** redness?	1. Yes 2. No
2j(4).	synovial thickening?	1. Yes 2. No
2j(5).	ROM (including spine) in degrees **(degrees not necessary for a "Yes" if ROM normal)**?	1. Yes 2. No

2k.	Muscle bulk ***or*** atrophy?	1. Yes 2. No
2l.	Muscle spasm **or** tone (includes any comment noting spasticity, flaccidity, rigidity, softness, and/or firmness?	1. Yes 2. No
2m.	SLR/tension signs **in degrees (degrees not necessary for No. 2)**?	1. Yes (SLR was abnormal) 2. Yes (SLR was normal) (Go to Strength 2n) 3. No (Go to Strength 2n)
2m(1).	If abnormal, was it confirmed in another body position?	1. Yes 2. No
2n.	Strength (if abnormal, per specific muscle groups)?	1. Yes 2. No
2o.	Cranial Nerves?	1. Yes 2. No
2p.	Sensation?	1. Yes 2. No
2q.	Deep Tendon Reflexes?	1. Yes 2. No
2r.	Oriented to person, place, **and/or** time?	1. Yes **2.** No
2s. **CHILD PHYSICALS ONLY**	Rectal exam?	1. Yes 2. No
2t. **CHILD PHYSICALS ONLY**	Genital abnormalities?	1. Yes 2. No

7. SECTION K3: MUSCULOSKELETAL/ORTHOPEDIC EXAM: DID THE CE REPORT ADEQUATELY ADDRESS?

GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular attribute is germane to the allegations being evaluated. For example, for osteoarthritis of the knee, "sensation" does not need to be described with the same amount of detail as when the claimant alleges peripheral neuropathy. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are.

Item Number	Question	Response Options
3a.	Muscle spasm **or** tone (includes any comment noting spasticity, flaccidity, rigidity, softness, and/or firmness?	1. Yes 2. No
3b.	Joint ROM (including spine) **in degrees (degrees not necessary for a "Yes" if ROM normal)**?	1. Yes 2. No
3c.	SLR/tension signs **in degrees (degrees not necessary for No. 2.)**?	1. Yes (SLR was abnormal) 2. Yes (SLR was normal) (Go to Strength 3d) 3. No (Go to Strength 3d)
3c(1).	If abnormal, was it confirmed in another body position?	1. Yes 2. No
3d.	Strength (if abnormal, per specific muscle groups)?	1. Yes 2. No
3e.	Sensation?	1. Yes 2. No
3f.	Deep Tendon Reflexes?	1. Yes 2. No
3g.	Muscle bulk **or** atrophy?	1. Yes 2. No
3h.	Joint instability?	1. Yes 2. No

8. SECTION K4: NEUROLOGY EXAMS: DID THE CE REPORT ADEQUATELY ADDRESS?

GENERAL INSTRUCTIONS: To give a "Yes" response for the following physical attributes, consider whether or not the particular finding is germane to the allegations being evaluated. For example, for carpal tunnel syndrome, "speech and language functions" do not need to be described with the same amount of detail as when the claimant alleges residua from a stroke. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are.

Item number	Question	Response Options
4a.	Cranial Nerves?	1. Yes 2. No
4b.	Strength (if abnormal, per specific muscle groups)?	1. Yes 2. No
4c.	Fatigability?	1. Yes 2. No
4d.	Muscle bulk ***or*** atrophy?	1. Yes 2. No
4e.	Peripheral sensation?	1. Yes 2. No
4f.	Cortical sensation (e.g., stereoagnosis, extinction, and/or ignoring)?	1. Yes 2. No
4g.	Coordination?	1. Yes 2. No
4h.	Adventitious (spontaneous, non-volitional) movements (e.g., tremors, choreoform movements, tics, tardive dyskinesias)?	1. Yes 2. No
4i.	Deep Tendon Reflexes?	1. Yes 2. No
4j.	Superficial reflexes (e.g., the abdominal reflex, palmomental reflex)?	1. Yes 2. No
4k.	Pathologic reflexes (e.g., the Babinski sign, Hoffman sign)?	1. Yes 2. No
4l	Speech functions?	1. Yes – at least 4 items were addressed 2. Yes – 2 or 3 items were addressed 3. Yes – 1 item was addressed 4. Yes – but there was only mention of the group of speech functions and individual functions were not

8. SECTION K4: NEUROLOGY EXAMS: DID THE CE REPORT ADEQUATELY ADDRESS?		
		referred to or discussed 5. No
Where to find:	**Neurological Exam:** Issues to be considered here (**per POMS**) are – 1) Aphasia; 2) Dysarthria; 3) Stuttering; 4) Involuntary vocalizations; and 5) Whether speech is intelligible and fluent	
How to Code:	Code as "Yes" No. 1 if 4 or 5 of these items were specifically referred to. Code as "Yes" No. 2 if 2 or 3 of these items were specifically referred to. Code as "Yes" No. 3 if only 1 of these items was specifically referred to. Code as "Yes" No. 4 if Speech functions were referred to as a group, but no specific function was referred to. Code as "No" if none of the Speech functions were referred to individually or as a group.	
4m.	Cognition?	1. Yes – at least 4 items were addressed 2. Yes – 2 or 3 items were addressed 3. Yes – 1 item was addressed 4. Yes – but there was only mention of the group of cognitive functions and individual functions were not referred to or discussed 5. No
Where to find:	**Neurological Exam:** Issues to be considered here (**per POMS**) are – 1) Orientation; 2) Memory; 3) Calculation; 4) Insight; 5) General Understanding; 6) Fund of Knowledge	
How to Code:	Code as "Yes" No. 1 if 4 or 5 of these items were specifically referred to. Code as "Yes" No. 2 if 2 or 3 of these items were specifically referred to. Code as "Yes" No. 3 if only 1 of these items was specifically referred to. Code as "Yes" No. 4 if Cognitive functions were referred to as a group, but no specific function was	

8. SECTION K4: NEUROLOGY EXAMS: DID THE CE REPORT ADEQUATELY ADDRESS?		
	referred to. Code as "No" if none of the Cognitive functions were referred to individually or as a group.	
4n.	Emotion (mood ***or*** affect)?	1. Yes 2. No

9. SECTION K5: OPHTHALMOLOGY EXAMS: DID THE CE REPORT ADEQUATELY ADDRESS?

GENERAL INSTRUCTIONS: To give a "Yes" response for the particular physical attributes, consider whether or not the particular finding is germane to the allegations being evaluated. For example, for an allegation of cataracts, the retina does not need to be described with the same amount of detail as when the claimant alleges macular degeneration. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are. See: **http://www.uic.edu/com/eye/pdf/ophthalmic_dictionary_alphabetical.pdf** for commonly used abbreviations in ophthalmology

Item number	Question	Response Options
5a.	Best-corrected visual acuity (this includes use of appropriate technology for assessing young children)?	1. Yes 2. No
5b.	Visual field loss?	1. Yes 2. No
5c.	The external eye exam?	1. Yes 2. No
5d.	The pupils **and** pupillary responses?	1. Yes 2. No
5e.	Ocular motility?	1. Yes 2. No
5f.	A slit lamp examination of the anterior structures?	1. Yes 2. No
5g.	Intraocular pressure?	1. Yes 2. No
5h.	A funduscopic examination?	1. Yes 2. No
5i.	Was there a **specific comment** that the claimant's identification was verified during the physical exam?	1. Yes 2. No
Where to find:	**CE Report Introduction**: There is often an indication that identification was verified using a Drivers License, other picture ID, or unique physical attribute, etc., at the beginning of the CE Report or at the beginning of the Eye Exam section.	
How to code:	• Code as "Yes" if ID verification was **specifically** noted. • Code as "No" if ID verification was **not specifically** noted.	

5j.	Was ***any*** part of the ophthalmological exam recorded on a standardized form?	1. Yes 2. No
Where to find:	Look for a pre-printed form (table or chart) within the CE document that has specific standard items relevant to any part of an Ophthalmological Physical Examination listed on it. The expectation is that the CE provider will "fill-in" the form to record part or the entire Eye Examination in lieu of describing such items in a free-hand paragraph or sentence format on a "blank file sheet." **NOTE:** In rare circumstances, the "pre-printed form" might be within a SEPARATE DOCUMENT in eView.	
How to code:	• Code as "Yes' if any part of the ophthalmological Examination is recorded on a standardized form. • Code as "No" if the entire ophthalmological Examination is recorded in free-hand paragraph or sentence format on a "blank file sheet."	

10. SECTION K6: ENT EXAMS: DID THE CE REPORT ADEQUATELY ADDRESS?

GENERAL INSTRUCTIONS: To give a "Yes" response for the particular physical attributes, consider whether or not the particular finding is germane to the allegations being evaluated. For example, for a peripheral hearing deficit, the larynx does not need to be described with the same amount of detail as when the claimant alleges vocal cord dysfunction. When the particular finding is relevant to the specific claim, enough detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, if applicable Listings are satisfied, and/or what residual capacities for work are. See: **http://www.ent.ufl.edu/files/forms/Common%20ENT%20Abbreviations-Acronyms%20-%20per%20WOC%2012-26-07.pdf**
For commonly used abbreviations in ENT.

Item number	Question	Response Options
6a.	The external ears?	1. Yes 2. No
6b.	The external auditory canals?	1. Yes 2. No
6c.	The tympanic membranes **and** middle ear?	1. Yes 2. No
6d.	The mastoids?	1. Yes 2. No
6e.	The nose **and** oral cavity?	1. Yes 2. No
6f.	Weber **and** Rinne tests?	1. Yes 2. No
6g.	The larynx?	1. Yes 2. No
6h.	Whether speech can be heard, understood, ***or*** sustained?	1. Yes 2. No
6i.	Was there a **specific comment** that the claimant's identification was verified during the physical exam?	1. Yes 2. No
Where to find:	**CE Report Introduction**: There is often an indication that identification was verified using a Drivers License, other picture ID, or unique physical attribute, etc., at the beginning of the CE Report or at the beginning of the ENT Exam section.	
How to code:	• Code as "Yes" if ID verification was **specifically** noted. • Code as "No" if ID verification was **not specifically** noted.	

6j.	Was ***any*** part of the ENT exam recorded on a standardized form?	1. Yes 2. No
Where to find:	Look for a pre-printed form (table or chart) within the CE document that has specific standard items relevant to any part of an ENT Physical Examination listed on it. The expectation is that the CE provider will "fill-in" the form to record part or the entire ENT Examination in lieu of describing such items in a free-hand paragraph or sentence format on a "blank file sheet." **NOTE:** In rare circumstances, the "pre-printed form" might be within a SEPARATE DOCUMENT in eView.	
How to code:	• Code as "Yes' if any part of the ENT Examination is recorded on a standardized form. • Code as "No" if the entire ENT Examination is recorded in free-hand paragraph or sentence format on a "blank file sheet."	

11. SECTION L: MENTAL HEALTH: DID THE CE REPORT ADEQUATELY ADDRESS?

GENERAL INSTRUCTIONS (expanded from the Website Template): To be considered "adequately addressed," enough clinical detail should be provided so that an examiner – with or without the assistance of a medical consultant – could determine if an impairment is severe, and if so, whether applicable Listings are satisfied, and what residual cognitive and behavioral capacities for work are. Credit should be given ("Yes" response) if the CE provider elicited the appropriate response(s) even if s/he did not immediately "analyze" the significance of the specific responses(s). The issue of analysis is considered in Sections N and O below.

Where to find: The information needed to evaluate the specific issues queried will be described in the body of the CE Report and/or in the results of ancillary psychological tests. The Section L question categories below do not have to be explicitly referred to by name in the CE Report in order to conclude that the particular issue was adequately elicited and/or evaluated. The listed possible questions and descriptors for the various questions **are obviously only examples** and are not meant to be exhaustive of the available types of questions/requests or necessarily be taken literally. Also, since this is a Study of the utility of CE's for assisting in claim adjudication, an adequate assessment of the issues below requires that they be evaluated in terms of current significance for the claimant, not just in terms of their status at some (remote) time in the past.

Obviously in a Mental Health CE, the competent CE provider is "examining" the claimant for various intellectual and emotional characteristics while the Medical History is being obtained, and not just during the "formal" Mental Status portion of the CE, if there was one. Thus, if there is a comment in the Medical History that clearly relates to one or more of the Mental status exam elements, e.g., the claimant reports he "sees shadows" or "hears voices," and it is reasonable to conclude that the provider recognized that such a comment represented a hallucination, then the provider should be credited with demonstrating the item - in this example hallucinations - even if the item (hallucinations) is not mentioned in the Mental Status exam section. (That is, in this example, give credit for demonstrating hallucinations in the appropriate mental status item.)

For purposes of this Study, please consider hallucinations and closely related issues, e.g., how the claimant recognizes and responds to real or unreal external or internal stimuli, as perceptual abnormalities, **AND NOT issues related to thought processes or content**.

Occasionally, a summary statement appears in a CE Report that probably relates to more than one element of a Mental status exam. For example, a comment such as "There are no signs of psychosis" could relate to thought content, thought processes, **and/or** perceptual abnormalities. Although in this situation we "hope" that all three issues have been addressed, there is no documentation of such. Also, the relevance of these aspects of a Mental Status exam are not only relevant to a psychotic disorder. Therefore, in order to "give credit" for assessing these items (thought content, etc.) they should be individually referred to in the CE Report.

Item Number	Question	Response Options

1.	Was there a **specific comment** that the claimant's identification was verified during the mental status exam?	1. Yes 2. No
Where to find:	**CE Report Introduction**: There is often an indication that identification was verified using a Drivers License, other picture ID, or unique physical attribute, etc., at the beginning of the CE Report or at the beginning of the Mental Status Exam section.	
How to code:	• Code as "Yes" if ID verification was **specifically** noted. • Code as "No" if ID verification was **not specifically** noted.	
2.	Did the CE provider assess: general appearance, behavior, **and/or** speech?	1. Yes - at least 2 of 3 items were addressed 2. Yes – only 1 item was addressed 3. No
Where to find:	This information will typically be included in the Mental Status Section of the CE Report. In some instances, however, relevant observations might be found on a separate form, in the case Discussion/Analysis, and/or in the MSS. Appearance - possible descriptors: hygiene, posture, dress, etc. Behavior - possible descriptors: facial expression, gestures, gaze direction, compulsions, etc. Speech - possible descriptors: 1- Quantity (spontaneous, poverty, loquacious, etc.) 2- Rate (pressured, slow, etc.) 3- Volume (weak, loud, soft, etc.) 4- Fluency (hesitant, quality of articulation, slurred, etc.)	
How to code:	• Code as "Yes" No. 1 if at least 2 or these three items (general appearance, behavior, **and/or** speech) were commented on. • Code as "Yes" No. 2 if only 1 of these items was commented on. • Code as "No" if none of these items were	

	commented on.	
3.	Did the CE provider assess thought processes?	1. Yes 2. No
Where to find:	HOW DOES THE CLAIMANT THINK? Possible descriptors: incoherent, circumstantial, linear, blocking, tangential, loosening of associations, perseverating, etc.) This information will typically be included in the Mental Status Section of the CE Report. "Thought Processes" are sometimes referred to as "Mental Activity" or "Stream of Speech and Mental Activity." In some instances, however, relevant observations might be found in the Medical History, on a separate form, in the case Discussion/Analysis, and/or in the MSS.	
How to code:	● Code as "Yes" if Thought Processes are commented on whether or not specific questions/requests were employed to elicit data about Thought Processes. ● Code as "No" if Thought Processes were not elicited in any form and were not otherwise commented on.	
4.	Did the CE provider assess thought content?	1. Yes 2. No
Where to find:	WHAT DOES THE CLAIMANT THINK ABOUT? Possible descriptors: suicidal or homicidal, delusional, paranoid ideation, preoccupied (e.g., somatically), obsessed, etc. This information will typically be included in the Mental Status Section of the CE Report. In some instances, however, relevant observations might be found in the Medical History, on a separate form, in the case Discussion/Analysis, and/or in the MSS.	
How to code:	● Code as "Yes" if Thought Content is addressed in the CE Report. **NOTE:** Give credit ("Yes" response) if Thought Content can be inferred from the general description of the Medical History and Mental Status exam, i.e., even if questions/requests as	

	noted above are not listed in the CE Report. ● Code as "No" if Thought Content cannot be inferred from the CE Report.	
5.	Did the CE provider assess perceptual abnormalities?	1. Yes 2. No
Where to find:	This information will typically be included in the Mental Status Section of the CE Report. In some instances, however, relevant observations might be found on a separate form, in the case Discussion/Analysis, and/or in the MSS. Possible descriptors: hallucinating (auditory, visual, tactile, etc.), responds to internal stimuli, depersonalized, etc.	
How to code:	● Code as "Yes" if Perceptual Abnormalities are addressed in the CE Report. **NOTE:** Give credit ("Yes" response) if the presence of Perceptual Abnormalities can be inferred from the general description of the Medical History and Mental Status exam, i.e., even if questions/requests as noted above are not listed in the CE Report. ● Code as "No" if the presence of Perceptual Abnormalities cannot be inferred from the CE Report.	
6.	Did the CE provider assess mood **or** affect?	1. Yes 2. No
Where to find:	This information will typically be included in the Mental Status Section of the CE Report. In some instances, however, relevant observations might be found on a separate form, in the case Discussion/Analysis, and/or in the MSS. Mood – Possible descriptors: 1-Euphoric? 2-Depressed 3-Angry 4-Sad 5-Happy Affect – Possible descriptors:	

	1-Appropriateness (congruent with thoughts) 2-Variability (labile, even) 3-Range (restricted, broad) Intensity (flat, normal) 5-Quality (detached, euthymic, animated, hostile)	
How to code:	● Code as "Yes" if either Mood (subjective) or Affect (objective) was addressed. ● Code as "No" if neither Mood not Affect was addressed.	
7.	Did the CE provider assess cognition (i.e., concentration, memory, intellectual functioning, ***and/or*** include a mini-Mental Status exam)?	1. Yes 2. No
Where to find:	This information will typically be included in the Mental Status Section of the CE Report. In some instances, however, relevant observations might be found on a separate form, in the case Discussion/Analysis, and/or in the MSS. Concentration (Attention) Possible descriptors: digit span, spell backwards, various calculations Memory Possible questions: Recent memory (What time was your appointment? What medication did you take today?) Remote memory (What is your SSA number? When did you graduate from high school?) Immediate memory (give a series of names of objects; ask to have them repeated immediately and after several minutes) Intellectual Fund of knowledge (last 3 Presidents, Capital of USA, Whose picture is on a dollar bill?) Vocabulary - possible descriptors: grade school level, consistent with educational achievement Abstraction Similarity (How are a watch and a tape measure similar?) Proverbs (What is the meaning of: "Don't cry over spilled milk? Or "A bird in the hand is worth two in the bush?)	
How to code:	● Code as "Yes" if either concentration and/or memory and/or intellectual functioning was	

	addressed, and/or if a mini-Mental Status exam was included in the CE Report. ● Code as "No" if none of these items were addressed in the CE Report.	
8.	Did the CE provider assess judgment **or** insight either by directly asking a question(s) related to these capacities and/or by inferring the status of these capacities from the claimant's history?	1. Yes, based **only** on directly asking the claimant questions related to these issues. 2. Yes, based **only** on inferences from the claimant's history (e.g., substance abuse history, criminal history, interpersonal relationships, etc.). 3. Yes, based on **both** directly asking relevant questions **AND** drawing inferences from the claimant's history. 4. No
Where to find:	This information will typically be included in the Mental Status Section of the CE Report. In some instances, however, relevant observations might be found on a separate form, in the case Discussion/Analysis, and/or in the MSS. Judgment Possible questions: 1-If you found a stamped and addressed envelope on the street, what would you do with it? 2-If you were in a theater and smelled smoke, what would you do? 3-How would you get home from this office? Insight Possible questions: 1-What is causing your health-related problem? 2-Do you think that your thoughts and moods are abnormal? 3-Why are you here today? Note: Judgment and/or Insight might also be addressed in the CE by inferring these capacities based on aspects of the claimant's history, e.g.,	

	drug abuse history, criminal history, etc., as opposed to directly posing questions/requests aimed at eliciting specific thought processes during the CE.	
How to code:	• Code as "Yes" (No. 1) if the CE provider assessed Judgment and/or Insight only by eliciting specific thought processes during the CE (using the types of questions/requests noted above). • Code as "Yes" (No. 2) if the CE addressed Judgment and/or Insight, but only by inferring either or both of them from aspects of the claimant's history, i.e., no direct questions/requests were posed. • Code as "Yes" (No. 3) if both direct questions/requests were posed **AND** the CE provider also drew inferences about Judgment and/or Insight from aspects of the claimant's history. • Code as "No" (No. 4) if neither Judgment nor Insight were addressed.	
9.	Was the mental status examination independently, i.e., directly, elicited and not inferred from a written instrument?	1. Yes 2. No
10.	Was the CE performed through a videoconference?	1. Yes 2. No
How to code:	• Code as "Yes" only if it is directly stated that the CE was performed via videoconference. • Code as "No" if unknown or not directly stated.	
11.	Was any part of the Mental Status exam recorded on a standardized form?	1. Yes 2. No
Where to find:	Look for a pre-printed form within the CE document that has specific standard items relevant to any part of the Mental Status exam listed on it. The expectation is that the CE provider will "fill-in" the form to record part or the entire Mental Status exam in lieu of describing such items in a free-hand paragraph or sentence format on a "blank file sheet."	
How to code:	• Code as "Yes' if any part of the Mental Status exam is recorded on a standardized form.	

	• Code as "No" if the entire Mental Status exam is recorded in free-hand paragraph or sentence format on a "blank file sheet."	

12. SECTION M: LAB STUDIES/X-RAYS/TESTS		
GENERAL INSTRUCTIONS: Consider here ONLY those lab tests, psychological/cognitive tests, and/or X-rays that were either ordered by SSA and actually performed by the clinical CE provider or, if ordered separately by SSA, were expected to be available (i.e., the results) to the CE provider for inclusion into the clinical CE provider's case discussion/analysis and list of diagnoses.		
Item Number	**Question**	**Response Options**
1.	Were any lab tests, psychological/cognitive tests, and/or X-rays ordered **and** performed along with the clinical CE or added on during the CE?	1. Imaging studies-**only** 2. Lab studies (e.g., blood, EKG, etc.)-**only** 3. **Both** imaging and lab studies 4. Psychological studies (**INCLUDE** subjective psychological instruments (e.g., MMPI); **INCLUDE** objective tests (e.g., WAIS); **EXCLUDE** MENTAL **(and mini-Mental)** STATUS EXAMs) 5. No
Where to find:	**CE Report**: Usually found on separate sheets included within the CE Report document. However, if performed by the CE provider, this information might appear at the end of the CE Report before or after the discussion and diagnoses. **Separate Document within the E-file**: If not in the CE Report, this information might be in a separate document within the E-file. This includes situations in which the ancillary studies are attached to a different version (document) of the actual CE Report you are reviewing. Typically, this will be in a later version, if there is one.	
How to code:	Consider any lab tests, psychological/cognitive tests, and/or X-rays that were performed by the clinical CE provider or results that were expected to be available to the CE provider for inclusion into the clinical CE provider's case discussion/analysis and list of diagnoses. • Code as "Imaging studies-**only"** if the only test(s) ordered was an imaging study(ies) (e.g., chest X-ray). • Code as "lab study only" if the only test(s) ordered was a lab related study(ies) (e.g., EKG and/or blood tests). • Code as "imaging and lab studies" if a combination of these two types	

	of tests was ordered. • Code as "psychological studies" if a psychological/cognitive test(s) was ordered. • Code as "No" if there were no ancillary tests ordered.	
2.	Were any of the tests not compliant with requirements in the Listings of Impairments?	1. Yes 2. No
Where to find:	**CE Report**: Usually found on separate sheets included within the CE Report document. However, if performed by the CE provider, this information might appear at the end of the CE Report before or after the discussion and diagnoses. **Separate Document within E-file**: If not in the CE report, this information might be in a separate document within the E-file. This includes situations in which the ancillary studies are attached to a different version (document) of the actual CE Report you are reviewing. Typically, this will be in a later version, if there is one.	
How to code:	• Code "Yes" if a study was **not** in compliance with the Listings (e.g., forced expiratory maneuvers were not "satisfactory" during a PFT and reported results therefore are not valid for claim adjudication). • Code "No" if all studies with Listing standards were in compliance with the Listings.	
2a.	List the type of noncompliant study(s).	1._____ 2._____
3.	3. Did the CE provider discuss the test results in the CE Report you are reviewing?	1. Yes 2. No 3. CE provider did not have these results available when the CE Report version you are reviewing was generated.
Where to find:	**CE Report**: Discussion of ancillary studies will most often appear in the CE provider's overall case discussion at the end of the CE Report before or after the diagnoses are given. Occasionally, a separate comment regarding a test result might appear in association with the test result itself, e.g., on a PFT report, or as a stand alone comment after the clinical data. **NOTE: For purposes of this question, consider test interpretations by the clinical CE provider (**NOT **an outside vendor) to be included in the definition of "discussion."**	

How to code:	• Code as "Yes" if the results were specifically discussed (or interpreted) by the clinical CE provider for at least one ancillary study (give "credit" for *any* discussion). • Code as "No" if ancillary study results were available to the CE provider (even if they were not listed in the CE Report) but none of them were discussed or interpreted. • Code as Response No. 3 if the report(s) of ancillary studies first appeared in a later version of "hands-on" CE Report than the one you are reviewing, and you have reason to believe the CE provider did not have these results available when the CE Report version you are reviewing was generated. This scenario could be inferred if the case discussion in the version of the CE Report that included the ancillary studies was different form the case discussion in the version you are reviewing (e.g.., the later version did discuss the ancillary studies).	
4.	Was ***any*** lab test, psychological/cognitive tests, and/or X-ray, etc. associated with the CE Report ***you are reviewing*** unnecessary for adjudication?	1. Yes 2. No (Go to Section M5)
Where to find:	**CE Report**: Usually found on separate sheets included within the CE Report document. However, if performed by the CE provider, this information might appear at the end of the CE Report before or after the discussion and diagnoses. **Separate Document within the E-file**: If not in the CE report, this information might be in a separate document within the E-file. This includes situations in which the ancillary studies are attached to a different version (document) of the actual CE Report you are reviewing. Typically, this will be in a later version, if there is one.	
How to code:	• Code as "Yes" if ***any*** ancillary test performed in conjunction with ***your*** CE was unnecessary for adjudication. Include any "add-on tests" that were intended for review and incorporation *into your* CE Report. • Code as "No" if you did not find any ancillary study unnecessary.	
4a.	List the type of unnecessary procedure/test(s):	1. _____ 2. _____ 3. _____
5.	Did the worksheet note that the additional ancillary study needed was of a specialized ***or*** highly technical nature?	1. Yes 2. No
Where to find:	**Worksheet comments/entries**	
How to code:	• Code as "Yes" if there was a cited example of the additionally needed evidence that a TS could not provide, e.g., the TS did not have access to a	

	spirometer or EKG machine for needed studies (PFT or EKG, respectively). **Note:** this question refers to **ancillary tests only** (e.g., a PFT). It does **not** refer to mental status exams or other specialty clinical exams. • Code as "No" if no information was provided indicating whether the additionally needed evidence was "highly technical or specialized."	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
GENERAL INSTRUCTIONS: In this section you are asked to make assessments based on the data provided in the Medical History, objective examination (Physical or Interview as appropriate), and any ancillary studies.		
Item Number	**Question**	**Response Options**
1.	1. Did the CE provider include a discussion of the CE findings (from the Medical History and either the Physical or Mental Status Examination)?	1. Yes 2. No
Where to find:	**CE Report**: At the end of the CE Report before or after the diagnoses.	
How to code:	• Code as "Yes" if a discussion of the clinical CE findings was provided. A discussion describes how the CE provider identified potential differential diagnoses and determined the diagnoses actually made. It should also include an explanation if a symptom is listed as a diagnosis (i.e., why it was not possible to provide a more clinically or pathologically specific diagnosis). Rarely, a discussion might be provided without any diagnosis at all. Evaluate the discussion independent of any diagnostic descriptions. A comment at the end of the CE Report that essentially only says "see findings above" is not a discussion, nor is a listing of one or more diagnoses. • Code as "No" if there is no discussion or analysis of the clinical CE findings even if a diagnosis was provided. **NOTE:** For purposes of answering this question, ignore any discussion of ancillary tests, since that issue (including neuropsychological testing results) was queried in Question M3 above.	
2.	Was a reasonable diagnosis provided for each distinct allegation/impairment that was evaluated by the CE provider?	1. Yes – for all of them 2. Yes – For at least 1/2 of the allegations, but not for all of them 3. Yes – For some (less than 1/2) of the allegations 4. No, not for any allegations
Where to find:	**CE Report**: Diagnoses are listed at the end of CE Report. This question addresses whether the CE provider offered a satisfactory diagnosis (or other conclusion) for each allegation, impairment and/or complaint that the CE provider knew about and was *within the scope* of his/her type of CE. This includes allegations and impairments uncovered by the CE provider not heretofore alleged by the claimant to SSA. It does *not* include allegations made	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
	to SSA (see CASE DATA) that the CE provider might not have been made aware of - either by SSA or the claimant. However, to conclude the latter, there should be evidence of a complete Medical History with pertinent associated symptoms, an appropriate objective examination for the type of CE, etc. Otherwise, it should be presumed that the CE provider was aware of all relevant allegations. A "reasonable" diagnosis" implies that an impairment is described with sufficient pathologic detail that an examiner can determine whether a particular Listing(s) of Impairment(s) is met or equaled. Alternatively, a diagnosis is also "reasonable" if, short of this goal, the CE provider provided as much specificity as was reasonably possible given the specific CE findings that were obtained or that should have been obtained during the CE.	
How to code:	• Code as "Yes" (No. 1) if a reasonable diagnosis was provided for all of the allegations evaluated by the CE provider. • Code as "Yes" (No. 2) if at least half of the allegations had an associated reasonable diagnosis, but **NOT** all of them. Consider the comments "no diagnosis existed" or "diagnosis not possible" as acceptable diagnoses (i.e., give "credit" for a "Yes"). • Code as "Yes" (No. 3) "For some, etc." if some, but less than half, of the allegations had an associated reasonable diagnosis. Consider here also comments such as "no diagnosis existed" or "diagnosis not possible" as acceptable diagnoses (i.e., give "credit" for a "Yes"). • Code as "No" (No. 4) if a reasonable diagnosis was not provided for ***any*** allegation.	
3.	Were all allegations that SSA intended evaluation of **in this CE** addressed by the CE provider?	1. Yes 2. No
Where to find:	**Allegations at CASE DATA and documents in the E-file.** This question refers to two groups of allegations that are *within the scope* of the type of CE ordered by SSA: those that the CE provider was not informed about, and those that the CE provider knew about *or should have known about* by asking the claimant. To answer this question, the allegations reported to SSA (entered at CASE DATA) must be reviewed as well as the entire CE Report and any documents in the E-file sent by the DDS to the CE provider (e.g., the Invoice for the CE in the CE Report document or elsewhere).	
How to code:	• Code as "Yes" if the CE provider evaluated all allegations or impairments within the specialty of his/her type of CE that the CE provider knew about or should have known about. • Code as "No" if *any allegation* appropriate to the CE performed was not evaluated to any extent. Do not include here any allegation for which it is reasonable to conclude the CE provider did not know about it and could not	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
	have uncovered it.	
4.	Were all allegations or impairments that were evaluated or listed by the provider in the CE Report previously known to SSA (Form 3368, 3820, MER, or stated in the Purchase Order/Invoice)?	1. Yes 2. No
Where to find:	**CE Report:** Review entire CE Report as well as allegations noted at CASE DATA (based on Forms 3368, 3820, et al). Also review MER. Note if any issues considered by the CE provider were not previously alluded to in some way in SSA documents or Forms, or MER.	
How to code:	• Code as "Yes" if there was no allegation or impairment that the CE provider evaluated that was not referred to elsewhere in the file (Purchase Order, in CASE DATA (SSA Forms), or MER. • Code as "No" if there was an issue addressed by CE provider that was not previously alleged or otherwise known to SSA. **Note:** An issue might be known to SSA by virtue of being documented in MER, but the issue might not have been alleged to SSA as a contributing factor to being unable to perform gainful work. Assume all issues described in the MER are "known" to SSA.	
5.	Did the CE findings support **EVERY** diagnosis made by the CE provider?	1. Yes 2. No
Where to find:	**CE Report:** Review diagnoses at end of CE Report in light of the findings throughout the CE Report.	
How to code:	• Code as "Yes" if all diagnoses were supported by findings in the body of CE Report. **EXCLUDE** diagnoses outside the specialty of the type of CE you are reviewing which were listed only to apprise the DDS of their existence. • Code as "No" if there was any diagnosis that did not have supporting findings.	
6.	Was a prognosis provided?	1. Yes 2. No (Go to N8)
Where to find:	**CE Report**: Usually placed in the CE Report after the diagnoses are noted, but could be within the discussion/analysis of findings.	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
How to code:	• Code as "Yes" if claimant's prognosis was described. • Code as "No" if no prognosis was offered.	
7.	Was the prognosis supported by the CE findings?	1. Yes 2. No
Where to find:	**CE Report**: Review prognosis in light of the findings throughout the CE Report.	
How to code:	• Code as "Yes" if the prognosis was supported by the findings in the body of the CE Report. • Code as "No" if the prognosis was not supported.	
8.	Were the CE findings and conclusions generally consistent with the MER **related** to the issues evaluated in the CE?	1. Yes 2. No 3. There was no MER **related** to the issues evaluated in this CE
Where to find:	**CE Report**: Review entire CE Report, both findings and conclusions. Review all MER related to the issues evaluated by the CE provider.	
How to code:	• Code as "Yes" if the CE findings were consistent with any MER that related to the issues evaluated at the CE. • Code as "No" if there is an inconsistency between the related MER and the CE findings, regardless of when the MER was generated. Note that an inconsistency between the MER and the CE Report, especially if the MER is relatively "old," doesn't by itself establish which source is more or less accurate or inaccurate. Either or both sources might be accurate or inaccurate depending in part on when the MER was generated. • Code as "No related MER, etc." in situations in which there is no MER in the E-file related to the issues evaluated by the CE provider.	
9.	Was there an indication of a change in the applicant's condition that ***potentially could have*** affected his/her adjudicative status?	1. Yes 2. No
Where to find:	**Initial decisions:** Review the Worksheet, the claimant's allegations at CASE DATA, and all permanent documents in the E-file (Lower Yellow Section) leading up to *your* CE, and *your* CE Report. You are asked here if the body of data thus reviewed supports the conclusion that the claimant's diagnoses and/or severity (functional capacity) levels materially changed (improved or deteriorated) between the time the claimant first alleged eligibility for benefits	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
	to the SSA Field Office and the date *your* CE was ordered. Such changes in clinical and/or functional status are uncommon over this relatively short period of time. **Hearing Level decisions**: Review the claimant's original allegations, the Worksheet for the previous decision(s), MER from earlier decisions including CE Reports (**Recon and Initial** as necessary), MER obtained by the ALJ, *your* CE Report, and the ALJ opinion. You are asked here if the body of data thus reviewed supports the conclusion that the claimant's diagnoses and/or severity (functional capacity) levels materially changed (improved or deteriorated) between the time the claimant was last denied below (Recon or Initial), and the approximate date the ALJ elected to order a CE. **Note:** the time elapsed for Hearing Level decisions will normally be significantly greater than for initial decisions. Thus, material changes in the claimant's clinical and/or functional status are more common in this scenario because of the relatively longer time intervals involved, and the fact that the record is "open."	
How to code:	• Code as "Yes" for the decision level at issue if you find positive evidence of a clinical or functional change in the claimant's status that might have contributed to the decision to order a CE. • Code as "No" if you find no such evidence or, for ALJ decisions, if you conclude that the ALJ ordered ***your*** CE simply because of the passage of time (i.e., there was otherwise no other evidence for a change in the claimant's status).	
10.	**In your opinion**, based on MER in the E-file **at the time the CE was ordered**, was the CE needed to adequately evaluate the issues addressed at the CE for adjudication purposes? **NOTE: this question is only for INITIAL DECISIONS.**	1. Yes 2. No
Where to find:	**E-file:** Review the MER in the E-file. Also review the Worksheet to discern the examiner's rationale for ordering the CE.	
How to code:	• Code as "Yes" if the CE was needed **assuming there was NO OTHER impairment or basis for adjudicating the claim**; decide if the CE was needed based on the perspective that the claim had to be adjudicated only on the allegations evaluated by ***your*** CE. • Code as "No" if you concluded a CE was not needed because the available MER related to ***your*** allegations could have supported an informed claim decision.	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
11.	Do you agree with the ALJ that the MER (including any prior CE's) was not sufficient to support a claim decision without ***your*** current CE?	1. Yes 2. No
Where to find:	**E-file:** Review all relevant MER in the E-file, including documents in earlier decisions. Review the ALJ opinion.	
How to code:	• Code as "Yes" if you agree ***your*** CE was needed for an informed claim decision by the ALJ. • Code as "No" if you disagreed with the ALJ's decision to order this CE.	
12.	Did MER **related to the issues evaluated in *your* CE** appear after ***your*** CE was performed?	1. Yes 2. No
Where to find:	**E-file:** Review the MER documents in the E-file for the appropriate decision level (Initial or ALJ). Did MER that relates to ***your*** CE appear after *your* CE was ordered? This scenario is more likely to have occurred if the examiner did not wait one month before ordering ***your*** CE and/or the clinical status of the claimant regarding the allegations evaluated at ***your*** CE changed after ***your*** CE was performed.	
How to code:	• Code as "Yes" if MER documents **related to the issues evaluated in *your* CE** were added to the E-file after ***your*** CE was performed. • Code as "No" if no additional **related** MER appeared in the E-file for the appropriate decision level.	
13.	In **your** opinion, would the "late-arriving" MER have made ***your*** clinical ("hands-on") CE unnecessary?	1. Yes 2. No 3. I already had concluded the CE was unnecessary.
Where to find:	**E-file:** Review the E-file for MER documents added after ***your*** CE was performed.	
How to code:	• Code as "Yes" if the "late-arriving" MER was dated (generated) **before *your* CE was performed *and*** if, in your opinion, it would have made ***your*** CE unnecessary had it arrived on time. **Note:** only Code as "Yes" if the late-arriving MER dealt directly with the issues/allegations evaluated at ***your*** CE. • Code as "No" if the "late-arriving" **related** MER would not have made ***your*** CE unnecessary **or** it was generated after ***your*** CE was performed.	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
	• Code as Response No. 3: self-explanatory	
14.	Were ***any*** CE's performed at an **earlier** adjudicative level in the claim process? **NOTE:** This question is **NOT** limited to CE's in your specialty! This question **INCLUDES** CE's from prior applications that have been incorporated into eView.	1. Yes 2. No (Go to Section O)
Where to find:	**Permanent Docs**: Review the permanent documents (Lower Yellow Section) in earlier decisions to note if any CE's were performed.	
How to code:	• Code as "Yes" if CE's of **any specialty** were performed at either the Initial or Recon decision levels. • Code as "No" if no CE's of any type were performed at either the Initial or Recon decision levels.	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
15.	If so, what were the ALJ's **STATED reason(s)** (in his/her OPINION) for requesting ***your*** CE?	1. Because (answer a, b, c, d, **and/or** e as appropriate) a. Because a new impairment was alleged (in a newly implicated or previously implicated body system) b. Because of outdated MER or a change in the status of a previously alleged impairment c. Because of a conflict in supporting MER information d. Because a different type of specialty or subspecialty exam was sought to evaluate a previously evaluated allegation, e.g., an orthopod, as opposed to an internist, to evaluate previously alleged low back pain e. Because of any other **STATED** reason 2. ALJ did not state ***any*** reason for ordering ***your*** CE
Where to find:	Review the ALJ Opinion given that one or more CE's were performed earlier.	
How to code:	• Code as No. 1 a., b., c., d, **and/or** e according to whether the particular response(s) approximates the ALJ's STATED reason(s) for ordering ***your*** CE. • **NOTE**: **ONLY RECORD THE ALJ's STATED REASONS FOR GETTING THE CE; DO <u>not</u> ANSWER THIS QUESTION BASED**	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
	ON WHAT YOU THINK WERE THE ALJ's REASONS - OR WHAT WOULD HAVE BEEN YOUR REASONS - FOR GETTING *your* **CE!! THE ALJ MIGHT HAVE STATED MORE THAN ONE REASON FOR REQUESTING THE CE.** • Code as No. 2 "ALJ did not state …" if no reason for ordering ***your*** CE is explicitly stated in the ALJ Opinion.	
16.	Was the most recent prior CE from an earlier decision (**ANY SPECIALTY**!) within 6 months of the date the ALJ ordered **your** CE?	1. Yes 2. No
Where to find:	**Permanent Docs**: Review the permanent records (Lower Yellow Section) in earlier decisions to note if any CE's were performed within 6 months of the date ***your*** CE was ordered..	
How to code:	• Code as "Yes" if ***any*** CE from an earlier decision was within 6 months of the date your CE was ordered. • Code as "No" if there were no CE's from an earlier decision within 6 months of the date your CE was ordered.	

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT		
17.	**<u>If</u>** the earlier CE was in **your** specialty, what was the overall quality of the **earlier** CE Report (use Response 4 if not within your CE's specialty)?	**1. Materially deficient CE Report: needed correction.** The earlier CE Report contained **critical** errors and/or omissions. These rendered the Report not fully usable - without additional information - for evaluating the claimant's allegations *at the time the earlier CE was performed.* **2. Average quality CE Report: could be used to adjudicate the claim.** The earlier CE Report provided SSA with the data needed to adjudicate the claim properly; **BUT** the CE Report contained **non-critical** deficiencies (errors and/or omissions) compromising its overall quality. **3. High quality CE Report.** The earlier CE Report included all or most of the items and details that SSA could reasonably expect from this CE purchase. **4. Not relevant: different CE type.** All earlier CE's were not of the same specialty type as ***your*** CE.

13. SECTION N: CE REPORT ASSESSMENT BY THE MEDICAL CONSULTANT	
Where to find:	**Permanent Docs**: Review the permanent documents (Lower Yellow Section) in earlier decisions to note if any CE's were performed at earlier (lower) decision levels. If earlier CE's were performed, note if any were of the *same* specialty type as ***your*** CE. Select the most recent earlier CE of the *same specialty type*. **Note** to IM and Childhood reviewers: Evaluate the earlier CE if it was a Generalist exam or involved any subspecialty if ***your*** current CE is also a Generalist exam or involves any one of the subspecialties (i.e., exact exam subspecialty type matching is not necessary). **Note** to all other reviewers: only evaluate the earlier CE if it involves the same specialty as ***your*** CE.
How to code:	• Code as "1" if the earlier report needed additions and/or corrections that SSA could reasonably expect, and, unless corrected, the Report could not be used to support a fully informed claim decision. For example, if the examiner needed a specific item, e.g., clarification of the Chief Complaint, a more detailed examination of the musculoskeletal body system, or a substance abuse history, and did not get it, Code as "1." A more specific example might be: the claimant alleges a heart murmur or "aortic stenosis," and the physical examination of the HEART only says: "Normal Rhythm;" OR the claimant alleges asthma, and there is no sufficient medical history for establishing the frequency of severe attacks per Listing requirements. • Code as "2" if the earlier CE Report could have been used to decide the claim based on the issues evaluated at the CE, but it had multiple deficiencies compromising its overall quality. For example, it omitted several key components (e.g., inadequate diagnosis, no prognosis, etc.) • Code as "3" if the earlier CE Report was of high quality, providing SSA with all or most of the information it could reasonably expect from the specific CE purchase, with essentially all specific questions/requests addressed in the Report. . • Code as "4" if all earlier CE's were not of the same specialty type as ***your*** CE (see Generalist exam exception above).

14. SECTION O: MEDICAL SOURCE STATEMENTS INVOLVING FUNCTIONAL CAPACITIES OR CHILDHOOD DOMAINS (ADULTS/CHILDREN)		
GENERAL INSTRUCTIONS: A Medical Source Statement (MSS) is expected in all CE Reports. Might be at end of CE Report or on a separate sheet within CE Report file, or in a separate document in eView, e.g., might also be associated with a different version of the CE Report you are reviewing. If on a separate sheet, will often utilize a stylized format, i.e., a pre-printed chart or table format.		
Item Number	**Question**	**Response Options**
1.	1. Was a there a medical source statement (MSS) on a separate form in eView (same document as CE or in a separate document)?	1. Yes 2. No
Where to find:	**See General Instructions**.	
2.	Which of the following functional capacities were estimated for an adult physical CE whether on a separate form or at the end of the Medical History/Physical Exam, i.e., in the discussion or as a separate statement/list?	
Where to find:	**Formal separate MSS or described at *end* of Hx/PE. DO NOT INFER THESE ITEMS FROM FINDINGS (re hearing, etc.) WITHIN THE MEDICAL HISTORY OR PHYSICAL EXAMINATION. They must appear as conclusions after the H & P or on a separate form.** **For Sitting and Standing, since they are referenced to an 8 hour work day, it is adequate if a restriction is given as a "percent," e.g., 50% (= 4 hours.)** **The term "no restrictions" – or the equivalent is only adequate if the specific capacities to which the term is referenced are given, e.g., "Sit: "no restrictions." If the term "no restrictions" is meant to apply to all MSS capacities, e.g., including "travel," this designation is NOT adequate, because it is unknown whether or not the CE provider actually was considering all capacities when the statement "no restrictions" was made.**	
How to code:	• Code **BELOW** as "Yes" if the particular functional capacity was estimated whether or not it is relevant to the impairments established. **NOTE:** for some items ***a quantitative estimate*** **is required** e.g., 10 pounds frequently or 4 hours out of an 8 hour day, etc. • Code **BELOW** as "No" if the particular capacity was not provided (quantitatively when appropriate) whether or not it is relevant to the impairments established.	

14. SECTION O: MEDICAL SOURCE STATEMENTS INVOLVING FUNCTIONAL CAPACITIES OR CHILDHOOD DOMAINS (ADULTS/CHILDREN)		
2a.	Sit (for how long)	1. Yes 2. No
2b.	Stand (for how long)	1. Yes 2. No
2c.	Walk (for how long or how far or how often)	1. Yes 2. No
2d.	Lift (how much)	1. Yes 2. No
2e.	Carry (how much)	1. Yes 2. No
2f.	Handle/Finger objects	1. Yes 2. No
2g.	Hear	1. Yes 2. No
2h.	Speak	1. Yes 2. No
2i.	Travel	1. Yes 2. No
3.	Which of the following functional capacities were estimated for an adult Mental Health CE whether on a separate form or at the end of the Medical History/Physical Exam, i.e., in the discussion or as a separate statement/list?	
Where to find:	**Formal separate MSS or described at end of Mental Status exam.**	
How to code:	• Code **BELOW** as "Yes" if the particular functional capacity was estimated. • Code **BELOW** as "No" if the particular capacity was not provided whether or not it is relevant to the impairments established.	

14. SECTION O: MEDICAL SOURCE STATEMENTS INVOLVING FUNCTIONAL CAPACITIES OR CHILDHOOD DOMAINS (ADULTS/CHILDREN)		
3a.	Understanding and memory?	1. Yes 2. No
3b.	Concentration, persistence, and pace?	1. Yes 2. No
3c.	Social functioning?	1. Yes 2. No
3d.	Adaptation?	1. Yes 2. No
3e.	Capability of handling benefits?	1. Yes 2. No
4.	Which of the following functional abilities were described relative to children of the same age with no impairment? **NOTE:** If the CE related to the specialty of Speech Language Pathology, only domains 4a and 4c below are applicable. Therefore, for this type of CE, 4b, 4d, 4e, and 4f should **ALWAYS** be answered "No."	
Where to find:	**Childhood CE Report**: For O4a thru O4f, the abilities are usually provided at the end of Childhood CE Reports (for young children).	
How to code:	• Code **BELOW** as "Yes" if the ability was addressed to the extent that an informed claim decision can be made. • Code **BELOW** as "No" if not adequately documented.	
4a.	Acquiring and using information (hearing, communicative ability)?	1. Yes 2. No
4b.	Attending and completing tasks (attention span, following directions)?	1. Yes 2. No
4c.	Interacting and relating with examiner (orientation, affect/behavior)?	1. Yes 2. No
4d.	Moving about and manipulating objects (gross and fine motor skills)?	1. Yes 2. No
4e.	Caring for self (personal grooming as relevant for age)?	1. Yes 2. No
4f.	Health and physical well-being (physical health and	1. Yes

14. SECTION O: MEDICAL SOURCE STATEMENTS INVOLVING FUNCTIONAL CAPACITIES OR CHILDHOOD DOMAINS (ADULTS/CHILDREN)		
	medical needs)?	2. No

15. SECTION P: OVERALL COMPLETENESS OF CE REPORT		
GENERAL INSTRUCTIONS: Please note that there are two overall CE Report quality scales: a 3-point scale and a 5-point scale.		
Item Number	**Question**	**Response Options**
1.	Was the CE report signed by an acceptable medical source (provider) who **actually performed** the CE?	1. Yes 2. No
Where to find:	**CE Report**: At the very end of the CE Report.	
How to code:	• Code as "Yes" if the CE was performed by an acceptable medical source and an actual signature by the performing provider was given OR the signature was stamped OR it was noted that an electronic signature was performed. • Code as "No" if no form of signature, electronic or otherwise, was provided. • Code as "No" if there is a comment that the CE Report was dictated but not read. • Code as "No" if you have reason to believe the actual CE was performed by a physician extender (PA or nurse practitioner) (i.e., not an acceptable medical source) and only signed by a supervising physician. **NOTE:** See POMS 22510.010 re who can perform a CE.	

15. SECTION P: OVERALL COMPLETENESS OF CE REPORT		
2.	What is the overall quality of the CE Report **you are primarily reviewing?**	**1. Materially deficient CE Report: needed correction.** The CE Report contained critical errors and/or omissions. These rendered the Report not fully usable – without additional information - for evaluating the claimant's allegations. information **2. Average quality CE Report: could be used to adjudicate the claim.** The CE Report provided SSA with the data needed to adjudicate the claim properly; **BUT** the CE Report contained multiple **non-critical** deficiencies (errors and/or omissions) compromising its overall quality. **3. High quality CE Report.** The CE Report included all or most of the items and details that SSA could reasonably expect from this CE purchase.
Where to find:	**CE Report:** Review entire CE Report in light of MER and questions/requests posed by SSA.	
How to code:	• Code as "1" if the CE Report needed additions and/or corrections that SSA could reasonably expect, and, unless corrected, the Report could not be used to support a fully informed claim decision. For example, if the examiner needed a specific item, e.g., clarification of the Chief Complaint, a substance abuse history, or a prognosis, and did not get it, Code as "1." A more specific example might be: the claimant alleges a heart murmur or "aortic stenosis," and the physical examination of the HEART only says: "Normal Rhythm;" OR the claimant alleges asthma,	

15. SECTION P: OVERALL COMPLETENESS OF CE REPORT		
	and there is no sufficient medical history for establishing the frequency of severe attacks per Listing requirements. • Code as "2" if the CE Report could have been used to decide the claim, but it had multiple deficiencies compromising its overall quality. For example, it omitted several key components (e.g., an inadequate diagnosis, no prognosis, etc.) • Code as "3" if the CE Report was of high quality, providing SSA with all or most of the information it could reasonably expect from a CE, with essentially all specific questions/requests addressed in the Report.	
3.	Please **also** assess overall CE Report quality according to the following summary and 5-point scale: **The CE Report contained all of the information (expected findings, conclusions, and responses to specific SSA questions) that SSA "paid for."**	1. Strongly disagree. 2. Disagree 3. Neither agree nor disagree 4. Agree 5. Strongly agree.
Where to find	**CE Report:** Review entire CE Report in light of MER.	
How to code:	Code the quality of the CE Report according to the 5-point scale as follows – essentially F (No. 1), D (No. 2), C (No. 3), B (No. 4), A (No. 5).	

APPENDIX C:

IRR STATISTICS FOR MEDICAL CONSULTANT INSTRUMENT (ALL RESPONSE CATEGORY OPTIONS)

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Appendix Exhibit C.1. Worksheet Review

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
C1. Was a DDS worksheet in the E-file?	Yes	270	262	289	93.1%	0.529	p < .0001
	No	19	27				
C2. Was any reason given on your Worksheet for ordering your CE?	Yes	61	61	256	73.4%	0.268	p < .0001
	No	195	195				
C3. Did the Worksheet note that the CE was ordered to obtain more recent evidence?	Yes	15	13	27	55.6%	0.115	p > .10
	No	12	14				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chanSce.

Appendix Exhibit C.2. Medical Evidence Documentation

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
G1. Did the CE provider refer to Medical Records as a group or names of individual items in the CE report?	Yes, excludes no MER	124	128	289	77.2%	0.601	p < .0001
	Yes, includes no MER	29	19				
	No	136	142				
G2. Did the CE provider list at least one item of MER he/she reviewed in the CE Report?	Yes	77	73	96	87.5%	0.635	p < .0001
	No	19	23				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.3. Medical History and Present Illness

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
I1. Did the CE provider indicate in a separate comment who gave the medical history?	Yes, claimant only	69	50	289	76.5%	0.403	p < .0001
	Yes, claimant and another person	10	13				
	Yes, other person(s) only	1	1				
	No	209	225				
I2. Was there a comment in the CE Report about the reliability of the medical history?	Yes	80	47	289	81.0%	0.455	p < .0001
	No	209	242				
I3. Per Study definition, was there a Chief Complaint?	Yes	259	250	289	88.6%	0.458	p < .0001
	No	30	39				
I3a. Was the Chief Complaint clarified (differential diagnosis explored or a diagnosis confirmed)?	Yes	205	224	238	84.5%	0.142	p < .05
	No	33	14				
I3b. Was any information provided that reflected on the severity of the Chief Complaint-related medical condition?	Yes	214	212	238	83.2%	0.106	p > 10
	No	24	26				
I3c. Was the approximate time of onset of the Chief Complaint-related medical condition described?	Yes	184	163	238	75.6%	0.391	p < .0001
	No	53	75				
	Birth or before	1	0				
I3d. Was anything that made the Chief Complain-related medical condition better (including treatment) or worse described?	Yes	132	161	238	65.1%	0.275	p < .0001
	No	106	77				
I4. Were there any allegations or complaints possibly related to any medical condition, diagnosis, impairment, or process that was not related to the Chief Complaint?	Yes	187	221	289	72.3%	0.344	p < .0001
	No	102	68				
I4a. Was at least one other allegation not related to the Chief Complaint clarified (differential diagnosis explored or a diagnosis confirmed)?	Yes	128	149	164	76.2%	0.122	p < .10
	No	36	15				

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
I4b. Was any information provided that reflected on the severity of at least one non-CC allegation or possible impairment?	Yes	124	141	164	78.7%	0.324	p < .0001
	No	40	23				
I4c. Was the approximate time of onset of at least one non-CC allegation or possible impairment described?	Yes	95	81	164	67.1%	0.351	p < .0001
	No	67	83				
	Birth or before	2	0				
I4d. Was anything that made any non-CC allegation or possible impairment better (including treatment) or worse described?	Yes	83	78	164	67.7%	0.354	p < .0001
	No	81	86				
I5. Was there a history of inpatient/outpatient diagnostic/treatment experiences related to the CC or to a non-CC allegation or possible impairment?	Yes	221	247	289	73.0%	0.136	p < .05
	No	68	42				
I6. Was at least part of the Medical History described in narrative format?	Yes	282	276	289	93.1%	-0.033	p > .10
	No	7	13				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.4. Additional Medical History

Label		Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
J1.	Was a Review of Systems documented?	Yes	90	88	147	87.8%	0.744	p < .0001
		No	57	59				
J2.	Were any medications listed anywhere in the CE Report?	Yes	235	242	289	90.0%	0.669	p <.0001
		No medication was being taken	37	26				
		No	17	21				
J2a.	Was at least one dose regimen noted?	Yes	90	93	229	92.6%	0.845	p < .0001
		No	139	136				
J3.	Did the CE provider inquire about a history of use of alcohol and/or illicit substances?	Yes, both alcohol and illicit drugs	204	187	289	87.9%	0.756	p < .0001
		Yes, for alcohol only	40	50				
		Yes, for illicit drugs only	4	6				
		No	41	46				
J4.	Was the past medical history (PMH) noted?	Yes	252	267	289	86.5%	0.269	p < .0001
		No	37	22				
J6.	The work/school history (in the HPI, PMH, or a separate section) was sufficient?	Yes	217	249	289	86.2%	0.566	p < .0001
		No	72	40				
		Not relevant	0	0				
J7a.	Was the family medical history (FMH) noted?	Yes	70	72	147	95.9%	0.918	p < .0001
		No	77	75				
J7b.	Was the family medical history (FMH) pertinent to the claimant's allegations noted?	Yes	84	61	142	68.3%	0.382	p < .0001
		No	58	81				
J8.	Was any part of the Medical History recorded on a Standardized Form?	Yes	16	20	289	91.0%	0.23	p < .0001
		No	273	269				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.5. Physical Exam Findings

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
K1a. Was there a comment that the claimant's identification was verified at the CE?	Yes	13	16	147	93.9%	0.656	p < .0001
			13				
	No	134	1				
K1b. Was pulse rate, blood pressure, and/or respiratory rate recorded?			11				
	Yes, at least 2 of 3 items	118	5	147	95.2%	0.864	p < .0001
	Yes, 1 item was recorded	14	16				
	No	15	16				
K1c. Was station or gait described?			14				
	Yes	132	0	147	89.1%	0.222	p < .01
	No	15	7				
K1d. Was use of an assistive device referred to in the CE Report?	Yes, claimant uses a device which was described	12	17	147	72.1%	0.555	p < .0001
	Yes, claimant uses a device which was not described	14	8				
	Claimant does not use an assistive device	69	83				
	No	52	39				
K1e. Was the ability to dress/undress or other gross/fine hand functions described?	Yes	54	87	147	73.5%	0.494	p < .0001
	No	93	60				
K1f. Were weight and height noted?			13				
	Yes	138	7	147	98.0%	0.831	p < .0001
	No	9	10				
K1o. Was any part of the physical exam recorded on a Standardized Form?	Yes	50	54	147	74.1%	0.435	p < .0001
	No	97	93				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.6. Physical Exam Findings

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
K2a. Physical exam findings: Presence or absence of distress?	Yes	51	59	104	73.1%	0.463	p < .0001
	No	53	45				
K2b. Physical exam findings: Head, eyes, ears, nose, oral cavity?	Yes, at least 2 of 5 items were addressed	95	93	104	89.4%	0.406	p < .0001
	Yes, 1 item was addressed	6	9				
	Yes, but only HEENT findings were mentioned	2					
	No	1	2				
K2c. Physical exam findings: Lung auscultation?	Yes	104	103	104	99.0%	0	
	No	0	1				
K2d. Physical exam findings: Cardiac rhythm?	Yes	93	92	104	93.3%	0.658	p < .0001
	No	11	12				
K2e. Physical exam findings: Cardiac auscultation (heart sounds, murmur, and/or gallop)?	Yes, at least 2 of 3 items were addressed	83	83	104	87.5%	0.627	p < .0001
	Yes, 1 item was addressed	17	17				
	Yes, but only mention of cardiac group	0	1				
	No	4					
K2f. Physical exam findings: Abdomen, bowel sounds, ascites, tenderness, masses?	Yes, at least 3 of 5 items were addressed	63	73	104	83.7%	0.665	p < .0001
	Yes, 2 of 5 items were addressed	36	26				
	Yes, but only mention of abdominal group	3	1				
	No	2	4				
K2g. Physical exam findings: Peripheral pulses (wrist or feet) or carotid strength?	Yes	75	80	104	93.3%	0.823	p < .0001
	No	29	24				
K2h. Physical exam findings: Peripheral edema?	Yes	72	75	104	93.3%	0.838	p < .0001
	No	32	29				
K2j. Re Joints (including spine) and any myofascial findings?							
Effusion, or swelling?	Yes	49	57	104	88.5%	0.771	p < .0001
	No	55	47				
Tenderness or trigger/tender points?	Yes	54	62	104	76.9%	0.535	p < .0001
	No	50	42				
Heat or redness?	Yes	27	35	104	84.6%	0.635	p < .0001

	No	77	69				
Synovial thickening?	Yes	8	14	104	92.3%	0.597	p < .0001
	No	96	90				
ROM (including spine) in degrees?	Yes	99	100	104	95.2%	0.42	p < .0001
	No	5	4				
K2k. Physical exam findings: Muscle bulk or atrophy?	Yes	46	55	104	76.0%	0.522	p < .0001
	No	58	49				
K2l. Physical exam findings: Muscle spasm or tone?	Yes	32	50	104	73.1%	0.453	p < .0001
	No	72	54				
K2m. Physical exam findings: SLR/tension signs in degrees?	Yes, SLR was abnormal	12	9	104	78.8%	0.639	p < .0001
	Yes, SLR was normal	46	58				
	No	46	37				
	Not relevant	0	0				
K2m_1. Physical exam findings: If SLR was abnormal, was it confirmed in another body position?	Yes	1	2	6	83.3%	0.571	p > .10
	No	5	4				
K2n. Physical exam findings: Strength (if abnormal, per specific muscle groups)?	Yes	92	91	104	93.3%	0.682	p < .0001
	No	12	13				
K2o. Physical exam findings: Cranial nerves?	Yes	56	62	104	92.3%	0.844	p < .0001
	No	48	42				
K2p. Physical exam findings: Sensation?	Yes	86	93	104	93.3%	0.722	p < .0001
	No	18	11				
K2q. Physical exam findings: Deep tendon reflexes?	Yes	93	96	104	97.1%	0.827	p < .0001
	No	11	8				
K2r. Physical exam findings: Mental Status?	Yes	46	58	104	71.2%	0.431	p < .0001
	No	58	46				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.7. Orthopedic/Musculoskeletal Exam

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
K3a. Did the CE report adequately address muscle spasm or tone?	Yes	19	24	38	76.3%	0.526	p <.001
	No	19	14				
K3b. Did the CE report adequately address joint ROM in degrees?	Yes	37	34	38	92.1%	0.374	p < .01
	No	1	4				
K3c. Did the CE report adequately address SLR/tension signs in degrees?	Yes, SLR was abnormal	11	10	38	78.9%	0.661	p < .0001
	Yes, SLR was normal	21	18				
	No	6	10				
	Not relevant	0	0				
K3c1. If abnormal, was SLR/tension signs confirmed in another body position?	Yes	4	5	8	62.5%	0.25	p > .10
	No	4	3				
K3d. Did the CE report adequately address strength (if abnormal, per specific muscle groups?	Yes	34	32	38	94.7%	0.771	p < .0001
	No	4	6				
K3e. Did the CE report adequately address sensation?	Yes	31	32	38	97.4%	0.907	p < .0001
	No	7	6				
K3f. Did the CE report adequately address deep tendon reflexes?	Yes	34	33	38	92.1%	0.623	p < .001
	No	4	5				
K3g. Did the CE report adequately address muscle bulk or atrophy?	Yes	27	23	38	89.5%	0.769	p < .0001
	No	11	15				
K3h. Did the CE report adequately address joint instability?	Yes	11	8	38	86.8%	0.652	p < .0001
	No	27	30				

Source: Consultative Examination Data Collection Instrument

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Appendix Exhibit C.8. Neurology

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
K4a. Neurology: Cranial nerves?	Yes	5	5	5	100.0%	--	--
	No	0	0				
K4b. Neurology: Strength (if abnormal, per specific muscle groups)?	Yes	5	5	5	100.0%	--	--
	No	0	0				
K4c. Neurology: Fatigability?	Yes	0	0	5	100.0%		
	No	5	5				
K4d. Neurology: Muscle bulk or atrophy?	Yes	2	2	5	60.0%	0.167	p > .10
	No	3	3				
K4e. Neurology: Peripheral sensation?	Yes	4	4	5	100.0%	1	p < .05
	No	1	1				
K4f. Neurology: Cortical sensation?	Yes	0	0	5	100.0%		
	No	5	5				
K4g. Neurology: Coordination?	Yes	1	3	5	60.0%	0.286	p > .10
	No	4	2				
K4h. Neurology: Adventitious movements?	Yes	1	1	5	100.0%	1	p < .05
	No	4	4				
K4i. Neurology: Deep Tendon Reflexes?	Yes	4	4	5	100.0%	1	p < .05
	No	1	1				
K4j. Neurology: Superficial reflexes?	Yes	0	0	5	100.0%		
	No	5	5				
K4k. Neurology: Pathologic reflexes?	Yes	3	3	5	100.0%	1	p < .05
	No	2	2				
K4l. Neurology: Speech functions?	Yes, at least 4 items were addressed	0	0	5	60.0%	0.474	p < .05
	Yes, 2 or 3 items were addressed	1	1				
	Yes, I item was addressed	1	0				
	Yes, but only the group of speech functions	1	3				
	No	2					
K4m. Neurology: Cognition?	Yes, at least 4 items were addressed	0	0	5	80.0%	0.706	p < .01
	Yes, 2 or 3 items were addressed	1	1				
	Yes, 1 item was addressed	1	1				
	Yes, but only the group of cognitive functions	0					
	No	3	2				
K4n. Neurology: Emotion (mood or affect)?	Yes	2	4	5	60.0%	0.286	p > .10
	No	3	1				

Source: Consultative Examination Data Collection Instrument

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Appendix Exhibit C.9. Mental Health

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
L1. Was there a comment that the claimant's identification was verified during the mental status exam?	Yes	38	35	142	93.7%	0.834	p < .0001
	No	104	107				
L2. Did the CE provider assess: general appearance, behavior, and/or speech?	Yes, at least 2 of 3 items	133	130	142	93.7%	0.548	p < .0001
	Yes, 1 item was addressed	6	4				
	No	3	8				
L3. Did the CE provider assess thought processes?	Yes	125	125	142	90.1%	0.532	p < .0001
	No	17	17				
L4. Did the CE provider assess thought content?	Yes	122	122	142	83.1%	0.302	p < .001
	No	20	20				
L5. Did the CE provider assess perceptual abnormalities?	Yes	128	126	142	93.0%	0.627	p < .0001
	No	14	16				
L6. Did the CE provider assess mood or affect?	Yes	133	129	142	93.0%	0.509	p < .0001
	No	9	13				
L7. Did the CE provider assess cognition (i.e., concentration, memory, intellectual functioning)?	Yes	139	139	142	97.2%	0.319	p < .001
	No	3	3				
L8. Did the CE provider assess judgment or insight?	Yes, based only on direct questions	27	62	142	46.5%	0.302	p < .0001
	Yes, based on inferences from claimant's history	53	32				
	Yes, based on both questions and inferences	41	16				
	No	21	32				
L9. Was the mental status examination independently elicited?	Yes	139	137	142	95.8%	0.23	p < .01
	No	3	5				
L10. Was the CE performed through a video conference?	Yes	0	0	142	100.0%		
	No	142	142				
L11. Was any part of the Mental Status exam recorded on a Standardized Form?	Yes	1	1	142	100.0%	1	p < .0001
	No	141	141				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.10. Lab Studies/Exams/Tests

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
Ml. Were any lab tests, psychological tests, and/or X-rays ordered or added on during the CE?	Imaging studies only	23	30	289	91.7%	0.844	p < .0001
	Lab studies only	9	8				
	Both imaging and lab studies	2	4				
	Psychological studies	69	66				
	No	186	181				
M2. Were any of the tests not compliant with requirements in the Listings of impairments?	Yes	3	3	95	97.9%	0.656	p < .0001
	No	92	92				
M3. Did the CE provider discuss the test results in the CE Report you are reviewing?	Yes	78	74	95	85.3%	0.556	p < .0001
	No	13	19				
	CE provider did not have these results	4	2				
M4. Was any lab test or other test, associated with the CE Report, unnecessary for adjudication?	Yes	14	25	95	77.9%	0.336	p < .001
	No	81	70				
M5. Did the Worksheet note that the ancillary study needed was of a specialized or highly technical nature?	Yes	6	9	95	88.4%	0.207	p < .05
	No	89	86				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.11. CE Report Assessment by Medical Consultant

Label		Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
N1.	Did the CE provider include a discussion of the CE findings?	Yes	189	213	289	77.9%	0.481	p < .0001
		No	100	76				
N2.	Was a reasonably stated diagnosis provided for each allegation/impairment evaluated by the CE provider?	Yes, for all of them	222	221	289	69.6%	0.211	p < .0001
		Yes, for at least half	46	43				
		Yes, for less than half	11	12				
		No, not for any	10	13				
N3.	Were all allegations that SSA intended evaluation of in this CE addressed by the CE provider?	Yes	250	261	289	82.4%	0.142	p < .05
		No	39	28				
N4.	Were all allegations that were evaluated or listed by the provider previously known to SSA?	Yes	224	205	289	66.4%	0.128	p < .05
		No	65	84				
N5.	Did the CE findings support EVERY diagnosis made by the CE provider?	Yes	243	229	289	75.1%	0.171	p < .01
		No	46	60				
N6.	Was a prognosis provided?	Yes	88	82	289	86.9%	0.683	p < .0001
		No	201	207				
N7.	Was the prognosis supported by the CE findings?	Yes	65	62	66	92.4%	-0.025	p > .10
		No	1	4				
N8.	Were the CE findings and conclusions generally consistent with the MER?	Yes	263	261	289	84.1%	0.084	p < .10
		No	12	14				
		No MER related to this CE	14	14				
N9.	Was there an indication of a change in the applicant's condition that could have affected his/her ability to work?	Yes	37	18	289	83.0%	0.028	p > .10
		No	252	271				
N10.	In your opinion, based on MER at the time the CE was ordered, was the CE needed for adjudication purposes?	Yes	134	137	140	95.0%	0.199	p < .05
		No	6	3				
N11.	Do you agree with the ALI that the MER was not sufficient to support a claim decision without your current CE?	Yes	105	134	149	65.8%	-0.017	p > .10
		No	44	15				
N12.	Did MER related to the issues evaluated in your CE appear after your CE was performed?	Yes	92	80	289	79.9%	0.521	p < .0001
		No	197	209				
N13.	In your opinion, would the late-arriving MER have made your clinical CE unnecessary?	Yes	6	11	57	68.4%	0.074	p > .10
		No	46	45				

Label	Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
	I had already concluded the CE was unnecessary	5					
N14. Were any CE's performed at an earlier adjudicative level in the claim process?	Yes	75	83	289	86.2%	0.652	p < .0001
	No	214	206				
N15. ALJ's stated reason(s) for requesting your CE:							
Because a new impairment was alleged.	Checked	2	0	2	96.6%	0	
	Not checked	0	0				
Because of outdated MER or a change in the status of a previously alleged impairment.	Checked	4	3	4	88.1%	-0.062	p > .10
	Not checked	0	0				
Because of a conflict in supporting MER information.	Checked	2	1	2	98.3%	0.659	p < .0001
	Not checked	0	0				
Because a different type of specialty exam was sought to evaluate a previously evaluated allegation.	Checked	2	3	2	91.5%	-0.042	p > .10
	Not checked	0	0				
Because of any other stated reason.	Checked	2	3	2	91.5%	-0.042	p > .10
	Not checked	0	0				
ALJ did not state any reason for ordering your CE.	Checked	48	51	48	74.6%	0.063	p > .10
	Not checked	0	0				
N16. Was the most recent prior CE from an earlier decision within 6 months of the date the ALJ ordered your CE?	Yes	12	4	59	76.3%	0.026	p > .10
	No	47	55				
N17. If the earlier CE was in your specialty, what was the overall quality of the earlier CE Report?	Materially deficient CE Report	7	4	59	54.2%	0.309	p < .001
	Average quality CE Report	30	29				
	High quality CE Report	7	14				
	Not relevant, different CE type	15	12				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.12. Medical Source Statement and Functional Capacities

Label		Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
O1.	Was a formal medical source statement (MSS) on file?	Yes	156	153	289	80.3%	0.604	p < .0001
		No	133	136				
O2.	Which of the following functional capacities were estimated for an adult physical CE?							
O2a.	Sitting (for how long).	Yes	86	90	147	90.5%	0.802	p < .0001
		No	61	57				
O2b.	Standing (for how long).	Yes	87	89	147	90.5%	0.802	p < .0001
		No	60	58				
O2c.	Walking (for how long or how far).	Yes	87	90	147	88.4%	0.759	p < .0001
		No	60	57				
O2d.	Lifting (how much).	Yes	88	91	147	88.4%	0.757	p < .0001
		No	59	56				
O2e.	Carrying (how much).	Yes	84	89	147	88.4%	0.762	p < .0001
		No	63	58				
O2f.	Handle/finger objects.	Yes	89	90	147	85.7%	0.7	p < .0001
		No	58	57				
O2g.	Hearing.	Yes	69	83	147	81.0%	0.622	p < .0001
		No	78	64				
O2h.	Speaking.	Yes	46	71	147	73.5%	0.463	p < .0001
		No	101	76				
O2i.	Travel.	Yes	38	61	147	76.2%	0.481	p < .0001
		No	109	86				
O3a.	Understanding and memory.	Yes	113	125	142	81.7%	0.334	p < .0001
		No	29	17				
O3b.	Concentration, persistence, and pace.	Yes	102	118	142	70.4%	0.168	p < .05
		No	40	24				
O3c.	Social functioning.	Yes	114	119	142	81.0%	0.356	p < .0001
		No	28	23				
O3d.	Adaptation.	Yes	95	100	142	82.4%	0.591	p < .0001
		No	47	42				
O3e.	Capability of handling funds.	Yes	119	130	142	83.8%	0.261	p < .001
		No	23	12				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.

Appendix Exhibit C.13. Overall Completeness of CE Report

Label		Response Options	SSA	COMS	Rating Pairs	Percent Agreement	Kappa	P Value
P1.	Was the CE report signed by an acceptable medical source (provider) who actually performed the CE?	Yes, actual or electronic signature	263	278	289	90.7%	0.229	p < .0001
		No, unsigned	26	11				
P2.	What is the overall quality of the CE Report you are primarily reviewing?	Materially deficient CE Report	35	35	289	52.9%	0.046	p > .10
		Average quality CE Report	196	191				
		High quality CE Report	58	63				
P3.	The CE Report contained all of the information (findings, conclusions, responses to questions) that SSA paid for.	Strongly disagree	8	10	289	38.1%	0.064	p < .10
		Disagree	42	35				
		Neither agree nor disagree	60	83				
		Agree	162	131				
		Strongly agree	17	30				

Source: Consultative Examination Data Collection Instrument

Notes: The sample includes selected CEs rated jointly by SSA and COMS Medical Consultants. In total, the COMS and SSA team jointly reviewed 289 adult CEs, which were stratified by type of CE exam (Mental versus Physical) and determination level (initial versus hearings). The rating pairs columns indicate how many Medical Consultants from both teams reviewed the question. The ratings pairs can be less than 289 if only a subgroup answered a question. The percent agreement shows the exact agreement between COMS and SSA Medical Consultants. The p-values are associated with the kappa test of significance, which shows the probability of reviewers' agreement by chance.